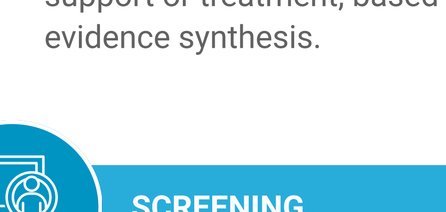
CHAPTER 10

How to Ask, Support, and Connect Women to Services: Screening, Brief Intervention, and Referral to Treatment (SBIRT)

10. How to Ask, Support, and Connect Women to Services: Screening, Brief Intervention, and Referral to Treatment (SBIRT)

10.1. Introduction to Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a public health model for engaging people who use substances, combining screening, brief intervention, and referral to specialty treatment (Harris, 2024). It is intended to provide generalist service providers, who may not be "experts" or specialists in substance use, with a pragmatic framework for engaging and supporting people who use substances so that, at minimum, people can be routinely screened and connected to care. SBIRT is widely implemented across primary care and behavioural health services and provides service providers with an easy-to-employ approach to supporting people who use substances.

We have synthesized key aspects of the rapid review into SBIRT categories to guide service providers with examples of screening, brief intervention, and referral to support or treatment, based on the evidence synthesis.



Screening can be conducted via interview, self-report, or computer-assisted methods. Computer-assisted screening may increase disclosure.

McKee, S. A., & Hilton, N. Z. (2017). Co-occurring substance use, PTSD, and IPV victimization: Implications for female offender services. Trauma, Violence, & Abuse, 20(3), 303–314. https://doi.org/10.1177/1524838017708782

In this toolkit, rather than using "screening" (asking with permission about substance use and GBV) in the traditional sense, we approach SBIRT as a universal, consent-led invitation to talk about safety, substance use, and well-being. This approach prioritizes respect, predictability, and centring the person's voice and asks permission before exploring these topics.

We begin by creating space: checking for privacy, explaining our role and limits, and offering the choice to talk about safety and substance use or not. A woman may be navigating many layers of harm, including coercion related to substance use, partner surveillance, or fear of losing her children. She may also be using substances in ways that help her cope or stay connected to her community.

By starting with transparency and respect, we help build trust and a sense of control, so the conversation belongs to her. Cross-screening should be standard practice across services. GBV services should routinely ask about substance use, and substance use services should routinely ask about GBV. These areas are often interconnected, and addressing one without considering the other may limit safety, engagement, and the overall effectiveness of support.

The brief intervention (support) is an opportunity to reflect on what we hear, what is helping, what is costing, and where pressure, control, or harm may be showing up. We avoid labels, assumptions, and judgment. Instead, we acknowledge the meaning behind her strategies and name the strengths she is already using to get through each day. When a woman feels heard rather than assessed, she is more able to consider what support might feel helpful right now.

From there, we co-create one small, doable next step. This may be a harm reduction strategy, a safety adjustment, a grounding practice, a resource she identifies, or simply a plan to reconnect at a time that feels safer. We honour her pace and can support her by facilitating a safety plan, a grounding practice, identifying a resource, or planning a reconnection at a time that feels safer. There is no expectation to disclose substance use reduction strategies, safety adjustments, grounding practices, resources, or a plan to reconnect at a time that feels safer. Our role is to open doors, not push her through them.

In this approach, referral (connect to support) is never a hand-off. It is a warm, supported connection to services that understand the realities of GBV, substance use, trauma, and colonial harms. Whenever possible, we offer choices and walk alongside her.

A warm referral may involve making the first call together, coordinating transportation or childcare, or linking with culturally grounded, women-only, or Indigenous-led programs. A good connection is one where she feels welcomed, respected, and safe enough to return.

Throughout SBIRT, we pay close attention to documentation, using neutral, non-stigmatizing language and noting patterns (such as coercion, forced substance use, and medication interference) that may help her in the future. We confirm who can access her records and plan for safety around appointment reminders and communication, while avoiding stigmatizing language and documenting patterns such as coercion, forced substance use, medication interference, financial control, emotional and psychological abuse, and legal control that may help her in the future.

Above all, SBIRT in this toolkit is about relationship, not risk management. By meeting women where they are, honouring their knowledge and choices, and offering realistic, compassionate pathways forward, we strengthen safety and autonomy and help make each encounter a place where healing can begin.

Findings from our rapid review of the literature and evidence have informed the content of this chapter.

SBIRT APPROACH

Ask • Support • Connect

A collaborative, woman-centred approach to safety, substance use, and wellbeing

ASK (Screening)	SUPPORT (Brief Intervention)	CONNECT (Referral to Services)
ask with permission about safety, substance use, and wellbeing.	reflect, explore options, strengthen coping, and co-create one small, doable next step.	make a warm, supported connection to services and resources that fit her needs and choices.

Throughout SBIRT, we honour her pace, her choices, and her strengths.
Our role is to open doors, not push her through them.

SCREENING

Reinforce cross-screening as a standard practice across services. All GBV services should screen for substance use, and all substance use services should screen for GBV.

Bennett, L., & O'Brien, P. (2007). Effects of coordinated services for drug-abusing women who are victims of intimate partner violence. Violence Against Women, 13(4), 395–411. https://doi.org/10.1177/1077801207299189

Four Anchors Approach — Micro-prompts on How to Ask (Screening)

How to Use the Four Anchors with SBIRT

Awareness:
"We ask everyone about safety and substance use to make support accessible and routine."

Safety & Trustworthiness:
"Before we start, is this a private time and place to talk?"

Choice/Collaboration/Connection: "Would it be okay if I ask a few brief questions, and you can skip anything you don't feel comfortable answering?"

Strengths & Skill-Building:
"What's already helping you feel safer, and what would help this week?"

4 ANCHOR APPROACH TO PROVIDING BRIEF SUPPORT

Awareness

"It makes sense to use what helps you get through. We can look at where it helps and where it costs."

Safety & Trustworthiness:

"We can go at your pace. There is no pressure to make decisions today."

Choice/Collaboration/Connection:

"Of the options we discussed, which—if any—feel like a good fit for now?"

Strengths & Skill-Building:

"Would a small safety adjustment or grounding practice be helpful this week?"

10.2 GENTLY, WITH PERMISSION: ASK ABOUT GBV AND SUBSTANCE USE ROUTINELY

We begin with privacy checks and a clear, plain-language explanation of our role and the limits of confidentiality. From there, we use brief, universal questions to invite conversation about safety, substance use, and well-being in a way that feels respectful and fair. Cross-screening helps reduce missed opportunities for support. We avoid labels, name coercion when present, and normalize coping. If the time or place isn't safe, we pause and plan a safer follow-up.

PRACTICE PEARL:

- When screening for GBV and substance use, use a universal, consent-led approach so questions feel routine and not targeted. Rather than making assumptions, normalize the conversation by asking open-ended questions and avoiding simple yes/no formats. You may preface with: "We ask everyone a few questions about safety, general health, and substance use. Would it be okay if I asked you those now?"
- Begin with more commonly discussed substances such as tobacco or alcohol and gradually move toward areas that may feel more sensitive, following the client's comfort and pace.

SCREENING

Screening for GBV and substance use should be conducted privately and without partners or family members present.

Goodman, D., Wolff, K. (2013). Screening for Substance Abuse in Women's Health: A Public Health Imperative. Journal of Midwifery & Women's Health, 58, 278-287. DOI: 10.1111/jmwh.12035

Salwen, J. K., Gray, A., & Mona, L. R. (2016). Personal assistance, disability, and intimate partner violence: A guide for healthcare providers. Rehabilitation Psychology, 61(4), 417–429. Kasseri, Z. (2025). Disclosure of problematic substance use and intimate partner violence: An exploratory study in Greece. Journal of Social Work Practice in the Addictions, 25(3), 316–330. https://doi.org/10.1080/1533256x.2025.2488818

Asking or "screening" for GBV and substance use is intended to be a simple set of questions that can be routinely asked of all service participants (clients) in ways that may flag the need for further assessment.

Unlike more comprehensive and detailed assessments, screening for GBV and substance use should be brief and general, with minimal probing, and intended to be asked universally and routinely to flag the need for further assessment as needed.

- **Exploring safety and GBV:**
  - Have there been times when you've felt unsafe or concerned about how someone is treating you?
  - Do you feel you have a place you can go or someone you can reach out to if you need support?

- **Exploring substance use:**
  - Would it be okay if we talked about substance use?
  - What role, if any, are substances playing in your life right now?
  - When was the last time you used any substances, such as alcohol, cannabis, or others?

SCREENING

Experiences of oppression decrease the likelihood of disclosure. Disclosure of both GBV and substance use is more likely when a person's basic needs are met.

Kasseri, Z. (2025). Disclosure of problematic substance use and intimate partner violence: An exploratory study in Greece. Journal of Social Work Practice in the Addictions, 25(3), 316–330. https://doi.org/10.1080/1533256x.2025.2488818

Possible Questions Providers May Ask to Assess Risk Factors for Intimate Partner Violence (IPV)

- Are you or your partner experiencing symptoms of sadness or depression?
- Do you currently or have you ever had a problem with alcohol or drug use?
- Have you ever felt like your partner needed to cut down on their drinking?
- Has your partner ever used prescription or illicit drugs during the course of your relationship?
- Do you and your partner often have verbal conflicts, including insulting or threatening each other?
- Are you unhappy in your relationship, or do you feel you and your partner are not well suited to each other?
- Do you and your partner often have verbal conflicts, including insulting or threatening each other?
- Have you and your partner ever had a physical altercation?
- Has your partner ever pressured or forced you to have sexual activity when you did not want to?
- Have you ever felt afraid of your partner or felt unsafe in the relationship?
- Have you ever felt like your partner was not responsive enough to requests for food, medication, showers, or bathroom assistance?
- Has your partner ever intentionally withheld needed care from you, such as refusing to take you to a medical appointment?
- Do you have the option to pay for personal assistance from someone other than your partner?

Salwen, J. K., Gray, A., & Mona, L. R. (2016). Personal assistance, disability, and intimate partner violence: A guide for healthcare providers. Rehabilitation Psychology, 61(4), 417–429. https://doi.org/10.1037/rep0000111

SCREENING

Provide information on and ask about experiences of substance use coercion.

National Center on Domestic Violence, Trauma & Mental Health. (2022). 7. Common Practices in Substance Use Disorder Care That Can Hurt Survivors and What You Can Do Instead. Retrieved from https://ncdvtmh.org/wp-content/uploads/2022/10/7-Common-Practices-Final.pdf

10.3 .GBV SCREENING TOOLS FROM THE LITERATURE: TOOLS THAT CAN SUPPORT MORE FOCUSED CONVERSATIONS ABOUT GBV WHEN APPROPRIATE

The following key screening tools for GBV were identified in our rapid review of the literature. The tools are evidence-informed but should be used with judgment regarding their appropriateness to the context and setting.

Use tools as conversation aids, not tests, by choosing brief, least-stigmatizing options first and following the woman's lead. The priority is safety and consent: if a tool feels too detailed at the moment, shift back to open-ended prompts and return to the tool when conditions feel safer.

The following tools can be found in the appendices:

SCREENING

Practitioners should explain that everyone is routinely screened for GBV to reduce the likelihood of clients feeling singled out.

Anyango, J., Renbarger, K. (2024). Thematic Synthesis of the Experiences of Intimate Partner Violence Among Mothers Who Use Substances. Nursing for Women's Health. DOI: 10.1016/j.nwh.2024.04.002

	HARK	HITS / E-HITS	WAST	PVS
Adm. Time:	**<2 minutes; self-report or clinician-administered**	**Administration Time: <2 minutes**	**Administration Time: 5-10 minutes**	**<1 minute**
About	HARK (Humiliation, Afraid, Rape, Kick) is a 4-item IPV screening tool designed for use in primary care settings to identify emotional, physical, and sexual abuse.	HITS (Hurt, Insult, Threaten, Scream) and E-HITS (Extended Version) are brief IPV screening tools that measure the severity of physical and emotional abuse.	The Woman Abuse Screening Tool (WAST) assesses emotional and physical abuse and is often used in reproductive health settings.	The Partner Violence Screen (PVS) is a 3-item screening tool validated for emergency and primary care settings.
Ideal Setting	Primary care, behavioural health, and community-based settings.	Outpatient, family practice, and community-based settings.	Reproductive health, primary care, and community settings.	Emergency, primary care
Pros:	Brief, validated, easy to administer	Validated, includes severity scoring (E-HITS)	Comprehensive, validated	Emergency, primary care
Cons:	Does not assess substance use	Does not include screening for sexual violence and does not assess substance use.	Does not include screening for sexual violence and does not assess substance use.	Limited in scope and does not assess substance use.

SCREENING

Screening for IPV during obstetric care should occur at the first prenatal visit, at least once during each trimester, and again at the postpartum visit.

All pregnant persons should be routinely screened for IPV throughout pregnancy.

Thematic Synthesis of the Experiences of Intimate Partner Violence Among Mothers Who Use Substances. Nursing for Women's Health. DOI: 10.1016/j.nwh.2024.04.002

10.4 COMBINED GBV, SUBSTANCE USE, AND PREGNANCY SCREENING TOOL:

In prenatal settings, use combined tools to reduce the need for repeated disclosures and to support perinatal safety. Maintain the same approach: consent-led, strengths-based, and transparent about any limits to confidentiality.

Choose tools that fit the setting and purpose, and remember that a score does not tell the full story. When results suggest risk, we reflect on meaning, identify strengths, and co-create one small, manageable next step (e.g., safer substance use, withdrawal support, or improving sleep).

4P's Plus

4P's plus screens for substance use and IPV among pregnant women by asking about parents, partners, past, and pregnancy.

- **Administration Time:** Approximately 5 minutes
- **Ideal Setting:** Prenatal care settings
- **Pros**: Screens for both IPV and substance use.
- **Cons:** Limited to use with pregnant women.

Psychological Maltreatment of Women Inventory – Short Version (PMWI-Short)

The Psychological Maltreatment of Women Inventory – Short Version (PMWI-Short) is a brief, validated screening tool designed to assess psychological and emotional abuse within intimate relationships. It can help providers identify patterns of coercion, domination, degradation, and control that may not surface through general questioning. The short version is practical for care settings because it is quick to administer and captures core indicators of psychological gender-based violence. It is a brief, validated screening tool designed to assess psychological and emotional abuse within intimate relationships. It can help providers identify patterns of coercion, domination, degradation, and control that may not surface through general questioning.

10.5 SUBSTANCE USE SCREENING TOOLS:

CAGE (Cut down, Annoyed, Guilty, Eye-opener)

The CAGE screening tool is a brief, widely used instrument designed to identify potential alcohol use disorders through four yes/no questions (Ewing, 1984).

CAGE-AID

The CAGE-AID (Adapted to Include Drugs) is a modified version of the original CAGE questionnaire that screens for both alcohol and other drug use disorders (Brown & Rounds, 1995).

It uses the same four questions as CAGE but broadens the scope by asking about alcohol and/or drug use (Brown & Rounds, 1995).

Example GBV Screening Questions

- Do arguments ever result in you feeling put down or bad about yourself?
- Has someone you know who uses substances harmed or threatened you or your children?
- Have you ever been forced to have unwanted sexual contact with your partner?
- Does anyone make it difficult for you to attend this service?
- Does your partner control whom you can or cannot see?

George, S., Boulay, S., & Galvani, S. (2011). Domestic abuse among women who misuse psychoactive substances: An overview for the clinician. Addictive Disorders & Their Treatment, 10(2), 77–87.

Women who experience intimate partner violence are at increased risk of returning to substance use. IPV and substance use coercion create unique risks that directly threaten safety and well-being.

National Center on Domestic Violence, Trauma & Mental Health. (2022, October 13). Substance use coercion as a barrier to safety, recovery, and economic stability: Implications for policy, research, and practice [Webinar]. https://ncdvtmh.org/training/independent-topic-substance-use-coercion-as-a-barrier-to-safety-recovery-and-economic-stability-implications-for-policy-research-and-practice/

SCREENING

Screening can be done via interview, self-report, or computer-assisted methods. Computer-assisted screening may increase disclosure.

McKee, S. A., & Hilton, N. Z. (2017). Co-occurring substance use, PTSD, and IPV victimization: Implications for female offender services. Trauma, Violence, & Abuse, 20(3), 303–314. https://doi.org/10.1177/1524838017708782

	AUDIT (Alcohol Use Disorders Identification Test)	**DAST** (Drug Abuse Screening Test)
Purpose	Detects hazardous and harmful alcohol use	Screens for problematic drug use
Structure	10 questions on alcohol consumption, dependence, and consequences	10- or 20-item questionnaire on drug use patterns and consequences
Administration Time:	2–3 minutes	2–5 minutes
Ideal Setting	Primary care and emergency settings	Primary care and behavioural health settings.
Strengths:	Highly validated and widely used globally	Validated for drug use and easy to administer

(Skinner, 1982).

SCREENING

Include screening for trauma exposure and post-traumatic stress disorder (PTSD) symptoms.

Brockdorf, A., Tilstra-Ferrell, E., Danielson, C., Moreland, A., Rheingold, A., Salim, A., Gilmore, A., Siciliano, R., Smith, D., Hahn, C. (2025). Characterizing Engagement with Web-Based Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Traumatic Stress and Substance Misuse After Interpersonal Violence. International Journal of Environmental Research and Public Health, 22(190).

SCREENING

Grouping IPV with other types of abuse in multipronged questions can confuse respondents. Clear, direct questions improve disclosure.

Hill, A. L., Miller, E., Borrero, S., Zelazny, S., Miller-Walfish, S., Talis, J., Switzer, G. E., Abebe, K. Z., & Chang, J. C. (2021). Family planning providers' assessment of intimate partner violence and substance use. Journal of Women's Health, 30(9), 1310–1317.

Let's walk through SBIRT in action—two minutes that can change a trajectory.

1. **Ask/Screen** (0–1 min): Universal introduction and routine safety prompts. **Universal safety:** "We ask everyone about safety at home and general health, including substance use, so that we can better support people."
2. **Brief Intervention** (1–3 min): LIVES and MI; **MI opener**: "What would a little more safety look like for you this week?"
3. **Referral:** Warm transfer now; confirm next steps; schedule follow-up. **Warm transfer:** "With your permission, I can call [Service] with you now, so you don't have to repeat everything."

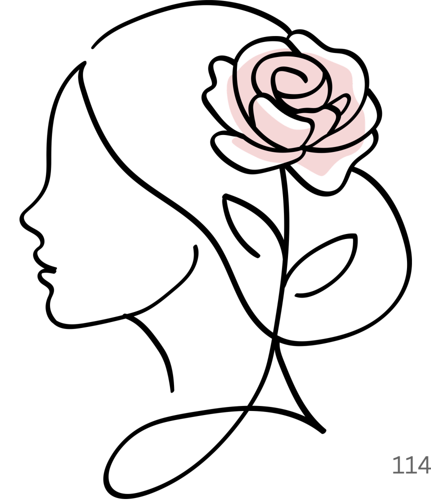
10.6 BEST PRACTICES FOR SUBSTANCE USE SCREENING IN IPV SETTINGS

- **Integrate Screening**: Combine IPV and substance use screening during intake and follow-up visits.
- **Trauma-Informed Approach**: Ensure privacy, confidentiality, and non-judgmental communication.
- **Ask About Substance Use Coercion**: Include questions about whether a partner pressures someone to use substances or sabotages recovery efforts.
- **Safety First**: Address immediate safety concerns before discussing substance use treatment goals.
- **Linkage to Services:** Provide referrals to IPV advocacy, substance use treatment, and mental health support.
- **Provider Training**: Educate staff on IPV dynamics, substance use coercion, and stigma reduction.

SCREENING

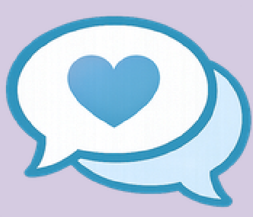
Screening alone, in the absence of intervention, has not been shown to improve outcomes.

Goodman, D., Wolff, K. (2013). Screening for Substance Abuse in Women's Health: A Public Health Imperative. Journal of Midwifery & Women's Health, 58, 278-287. DOI: 10.1111/jmwh.12035



10.7 BRIEF INTERVENTION:

Brief intervention refers to simple, practical engagement with clients about substance use and GBV. It includes screening, safety planning, and exploring goals and priorities in ways that foster self-efficacy, choice, and collaboration. A brief intervention focuses on what matters most today. We validate coping strategies, look for signs of pressure or control, and avoid pushing decisions. Where relevant, we incorporate grounding strategies, harm reduction, or small safety adjustments. If readiness increases, we can gradually introduce skills-based or therapy-adjacent supports without rushing trauma-focused memory work while harm is ongoing.



BRIEF INTERVENTION

Family-Centred and Wraparound Support

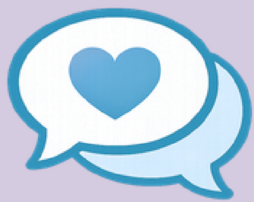
Family-centred treatment options should include understanding substance use in the context of mothering. Family-based approaches and parenting skill development are important components of care. Integrated, wraparound services that bring together multidisciplinary providers are essential for pregnant or newly parenting women.

Centre for Excellence for Women's Health (2024). Women's Substance Use Treatment and Recovery. Retrieved from: https://cewh.ca/wp-content/uploads/2024/10/Final-Womens-Substance-Use-Treatment-and-Recovery.pdf

Applying the 4 anchors for Brief Intervention Using EQUIP TVIC anchors

- **Awareness:** "It makes sense to use what helps you get through. We can look at how it helps and where it may be creating challenges."
- **Safety & Trustworthiness:** "We can go at your pace. There is no pressure to make decisions today."
- **Choice/Collaboration/Connection:** "Of the options we discussed, which, if any, feel like a good fit for now?"
- **Strengths & Skill-Building:** "Would a small safety adjustment or grounding practice be useful this week?"

Matching Support to Readiness for Change



BRIEF INTERVENTION

The Transtheoretical Model of Behaviour Change can guide interventions by assessing clients' stages of change related to substance use and IPV, helping providers tailor goals and strategies accordingly.

LynnKail, B. (2010). Motivating Women with Substance Abuse and Intimate Partner Violence. Journal of Social Work Practice in the Addictions 10(1), 25-43. DOI: 10.1080/15332560903526002

Advocacy, Safety, and Survivor-Centred Support

IPV advocacy typically includes crisis intervention, counselling, court advocacy, support groups, shelter services, and safety planning. It centres survivors as experts and uses an empowerment-based, strengths-based approach.

Stone, R., Campbell, J. K., Halim, N., Kinney, D., & Rothman, E. F. (2023). Design and pilot evaluation of a cross-training curriculum for intimate partner violence advocates and peer recovery coaches. Victims & Offenders, 18(2), 298–318. https://doi.org/10.1080/15564886.2022.2026544

PRECONTEMPLATION

Not thinking about change

Build trust, provide information, express care and concern.

Focus: Connection and safety.

CONTEMPLATION

Thinking about change

Explore ambivalence, reflect strengths, share options.

Focus: Empowerment and information.

PREPARATION

Preparing for change

Support planning, identify goals, build confidence.

Focus: Planning and encouragement.

ACTION

Taking steps toward change

Reinforce progress, problem-solve barriers, celebrate small wins.

Focus: Support and reinforcement.

MAINTENANCE

Sustaining change

Support ongoing growth, prevent relapse, connect to resources.

Focus: Strength, resilience, and long-term support.

Safety, choice, and connection are at the centre of every conversation.

Did you know?
Safety planning can be a beneficial initial intervention, even if it precedes therapeutic work.

Bailey, K., Trevillion, K., Gilchrist, G. (2020). "We have to put the fire out first before we start rebuilding the house": practitioners' experiences of supporting women with histories of substance use, interpersonal abuse, and symptoms of post-traumatic stress disorder. Addiction Research & Theory, 28(4). DOI: 10.1080/16066359.2019.1644323

BRIEF INTERVENTION

Providing tangible resources such as affordable housing, food, and clothing can address immediate needs and enhance safety and recovery.

Phillips, H., Lyon, E., Krans, E., Warshaw, C., Chang, J., Pallatino, C. (2021). Barriers to help-seeking among intimate partner violence survivors with opioid use disorder. International Review of Psychiatry, 33(6), 534-542. DOI: 10.1080/09540261.2021.1898350

10.8 EVIDENCE-INFORMED BRIEF INTERVENTIONS FOR SUPPORTING WOMEN EXPERIENCING GBV AND SUBSTANCE USE:

a. Screening and Brief Intervention: Use validated tools for substance use, GBV, and mental health within a single session. Apply motivational interviewing (MI) tailored to women's experiences, addressing stigma and safety concerns (Miller & Rollnick, 2013).

b. Safety Planning: Incorporate GBV safety planning into substance use sessions (World Health Organization [WHO], 2013). Discuss emergency contacts, safe housing options, and overdose prevention strategies.

c. Psychoeducation: Provide brief educational sessions on the connections between trauma, substance use, and GBV, along with coping strategies (Canadian Centre on Substance Use and Substance Use Disorder, 2020).

d. Harm Reduction: Offer gender-sensitive harm reduction services (e.g., overdose prevention, safer use kits) (Harm Reduction International, 2019). Address barriers women face in male-dominated harm reduction spaces.

e. Strengths-Based Approach: Centre women's resilience, competencies, and existing supports (Bailey et al., 2019). Focus on strengths rather than deficits to counter shame and stigma, build confidence, and empower women as agents in their own recovery (Bailey et al., 2019).

f. Mindfulness-Based Skills: Mindfulness practices have been shown to reduce anxiety, tension, and withdrawal-related distress, offering clients practical ways to calm the nervous system and manage overwhelming states (Schmidt et al., 2018).

g. Goal-Focused, Behaviour-Change Approaches: A structured, goal-oriented model—drawing from cognitive-behavioural strategies, motivational interviewing, and stages-of-change theory—supports clients in setting individualized goals across multiple areas of life. Programs using this approach have reported decreases in family conflict and meaningful reductions in participants' substance use (Brabete et al., 2024).

h. Somatic and Body-Based Therapies: Body-centred healing methods can help address the physical impacts of trauma and support regulation. These include movement-based practices, mind-body approaches, and complementary therapies such as massage, physical activity (e.g., walking, swimming), and trauma-informed yoga. Evidence highlights the value of body-oriented and mindfulness-based interventions, including trauma-sensitive yoga, in trauma recovery (Centre of Excellence for Women's Health, 2024; Lakin et al., 2022).

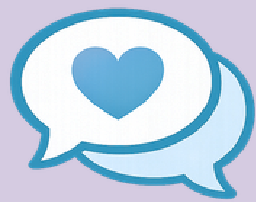
i. Cognitive Behavioural Therapy (CBT): CBT remains one of the most rigorously supported therapeutic approaches for treating substance use concerns, with strong clinical and research evidence identifying it as a gold-standard intervention (SAMHSA, 2009; APA, 2019).

The World Health Organization recommends CBT-based treatments, particularly for women who are no longer in violent situations but continue to experience PTSD symptoms (WHO, 2013, p. 30).

DID YOU KNOW?

Fear of child apprehension prevents women from talking about how experiences of violence have affected them. These fears are well-founded, as many people perceive women with mental health or substance use issues as incapable of parenting effectively.

BCSTH Staff, Reducing Barriers Working Group, Reducing Barriers Implementation Committee, Payne. S., Clifford, D. (2024). Reducing Barriers to Support for Women Fleeing Violence: A toolkit for supporting women with varying levels of mental wellness and substance use. https://bcsth.ca/wp-content/uploads/2024/10/ReducingBarrierToolkit-4-output.pdf



BRIEF INTERVENTION

Warshaw, C., & Tinnon, E. (2018, March). Coercion related to mental health and substance use in the context of intimate partner violence: A toolkit for screening, assessment, and brief counselling in primary care and behavioural health settings. National Center on Domestic Violence, Trauma & Mental Health. https://sprc.org/wp-content/uploads/2022/12/NCDVTMH_IPV_ScreeningMH_SA_CoercionToolkit2018.pdf

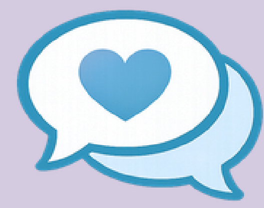
Responding to Mental Health and Substance Use Coercion: Implications for Clinical Practice

- Ask routinely.
- Validate perceptions, acknowledge impacts, and express concern.
- Collaborate to develop safe strategies for addressing coercive behaviours and their effects.
- Document in ways that link symptoms and the ability to participate in treatment to the abuse, and document efforts to protect and care for children.
- Provide linkages or "warm referrals" to community domestic violence (DV) resources.
- Incorporate these considerations into long-term treatment planning.
- Recognize the importance of ensuring that services are both domestic violence (DV)- and trauma-informed.

10.9 BRIEF INTERVENTION: SAFETY PLANNING FOR WOMEN EXPERIENCING GBV AND SUBSTANCE USE

Safety planning is collaborative and concrete, addressing urgent risks, overdose prevention, medication privacy, safer-use options, safe times and places to connect, and whom to call. Conditions may change, so plans should be short, specific, and regularly revisited.

Safety planning is a structured process that helps women identify strategies to stay safe and reduce harm. It is also a key brief intervention that all service providers can integrate into routine practice.

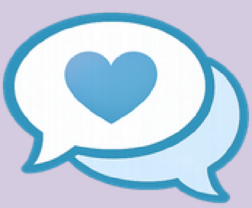


BRIEF INTERVENTION

Warshaw, C., & Tinnon, E. (2018, March). Coercion related to mental health and substance use in the context of intimate partner violence: A toolkit for screening, assessment, and brief counselling in primary care and behavioural health settings. National Center on Domestic Violence, Trauma & Mental Health. https://sprc.org/wp-content/uploads/2022/12/NCDVTMH_IPV_ScreeningMH_SA_CoercionToolkit2018.pdf

Responding to Mental Health and Substance Use Coercion: Implications for Clinical Practice

- Ask routinely.
- Validate perceptions, acknowledge impacts, and express concern.
- Collaborate to develop safe strategies for addressing coercive behaviours and their effects.
- Document in ways that link symptoms and the ability to participate in treatment to the abuse, and document efforts to protect and care for children.
- Provide linkages or “warm referrals” to community domestic violence (DV) resources.
- Incorporate these considerations into long-term treatment planning.
- Recognize the importance of ensuring that services are both domestic violence (DV)- and trauma-informed.



Integrating cultural practices, interactive learning, and entertainment-education methods (e.g., sharing circles, traditional teachings, and smudging) increases the engagement and relevance of interventions.

Varcoe, C., Browne, A. J., Ford-Gilboe, M., Dion Stout, M., McKenzie, H., Price, R., Bungay, V., Smye, V., Inyallie, J., Day, L., Khan, K., Heino, A., & Merritt-Gray, M. (2017). Reclaiming Our Spirits: Development and pilot testing of a health promotion intervention for Indigenous women who have experienced intimate partner violence. Research in Nursing & Health, 40(3), 237–254. https://doi.org/10.1002/nur.21795

BRIEF INTERVENTION

Key Components of Safety Planning

1. **Emergency Contacts:** Identify trusted individuals and local emergency services, including GBV hotlines (WHO, 2013). Store contact numbers safely and discreetly (WHO, 2013).

2. **Safe Housing:** Discuss emergency shelters, transitional housing options, and confidentiality measures (WHO, 2013). Connect clients to housing programs that accommodate women with substance use needs (WHO, 2013).

3. **Overdose Prevention for Women with Opioid Use:** Provide harm-reduction education and naloxone kits, and encourage the use of safer environments such as supervised consumption sites (Canadian Centre on Substance Use and Substance Use Disorder, 2020).

4. **Personalized Safety Strategies:** Develop plans for safely leaving a partner using abusive behaviours, securing important documents, and maintaining technology safety (WHO, 2013).

5. **Linkage to Services:** Connect women to GBV advocacy programs, substance use disorder treatment, and mental health supports through trauma-informed and gender-sensitive referrals (SAMHSA, 2009).

10.10 WHY INTEGRATE SAFETY PLANNING INTO SUBSTANCE USE SESSIONS

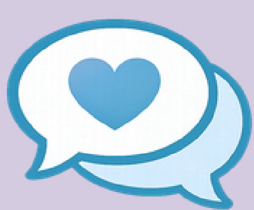
Women experiencing GBV often face an increased risk of overdose due to stress, coercion, or unsafe environments. Combining GBV safety planning with substance use support promotes holistic care and addresses both immediate safety and long-term recovery needs (WHO, 2013).

10.11 BRIEF INTERVENTION: MOTIVATIONAL INTERVIEWING (MI)

Motivational Interviewing (MI) is a person-centred, directive counselling approach designed to enhance intrinsic motivation for behaviour change by helping clients explore and resolve ambivalence (Miller & Rollnick, 2013). It emphasizes collaboration, empathy, and respect for autonomy rather than confrontation or unsolicited advice-giving (Miller & Rollnick, 2013).

Why MI Works for Women Experiencing Substance Use and IPV

- Addresses Ambivalence: Helps women explore conflicting feelings about leaving abusive relationships or reducing substance use.
- Empowers Decision-Making: Aligns with trauma-informed principles by supporting autonomy and avoiding coercion.
- Builds Readiness for Change: Effective for clients in the early stages of change, when readiness may be low.
- Integrates Holistic Care: MI can be combined with safety planning and harm reduction strategies.



BRIEF INTERVENTION

Responding to Mental Health and Substance Use Coercion: Implications for Domestic Violence (DV) Programs

→ Provide information about mental health and substance use coercion that offers perspective and helps reduce isolation and stigma.

→ Incorporate these issues into discussions about program accessibility, safety planning, risk assessment, support group topics, and legal advocacy.

→ Provide outreach, education, and advocacy in collaboration with community providers and systems.

Warshaw, C., & Tinnon, E. (2018, March). Coercion related to mental health and substance use in the context of intimate partner violence: A toolkit for screening, assessment, and brief counselling in primary care and behavioural health settings. National Center on Domestic Violence, Trauma & Mental Health. https://sprc.org/wp-content/uploads/2022/12/NCDVTMH_IPV_ScreeningMH_SA_CoercionToolkit2018.pdf

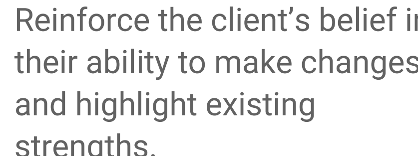
CORE PRINCIPLES OF MI

Express Empathy: Use reflective listening to validate feelings and experiences.

Develop Discrepancy: Help clients recognize the gap between current behaviours and personal values.

Roll with Resistance: Avoid arguing or imposing solutions; instead, reframe resistance as ambivalence.

Support Self-Efficacy: Reinforce the client's belief in their ability to make changes and highlight existing strengths.



BRIEF MI STRATEGIES FOR SERVICE PROVIDERS

- **Open-Ended Questions:** e.g., "What concerns do you have about your current situation?"
- **Affirmations:** e.g., "You've shown a great deal of strength in seeking help."
- **Reflective Listening:** e.g., "You feel torn between wanting safety and fearing change."
- **Elicit Change Talk:** e.g., "What would life look like if things were different?"

Evidence and Effectiveness

MI improves engagement, treatment adherence, and readiness for change among women experiencing co-occurring IPV and substance use issues. It is effective as part of Screening, Brief Intervention, and Referral to Treatment (SBIRT) models and increases motivation when combined with trauma-informed care.

Sample Motivational Interviewing Prompts for Service Providers

The following provides sample prompts for applying Motivational Interviewing (MI) techniques with women experiencing substance use and intimate partner violence (IPV). The examples are organized into the four stages of MI: Engaging, Focusing, Evoking, and Planning.

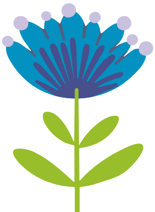
Engaging

Worker: Thank you for meeting with me today. How have things been for you recently?

Worker: I appreciate you sharing your experiences. It sounds like you've been dealing with a lot.

Focusing

Worker: You mentioned wanting things to feel safer at home and thinking about your substance use. Which of these feels most important to talk about today?



Evoking

Worker: "What would life look like if you felt safer and more in control?"

Worker: "On a scale of 1 to 10, how ready do you feel to make a change in your substance use?"

Worker: "Why did you choose that number and not a lower one?"

Planning

Worker: "What steps do you think you could take to feel safer and reduce your substance use?"

Worker: "Would you like to hear about some resources that other women have found helpful?"

Survivors may be reluctant to contact police in violent situations for fear of their own arrest or referral to the child welfare system.

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

Sample Brief Intervention Scripts for Substance Use (Motivational Interviewing)

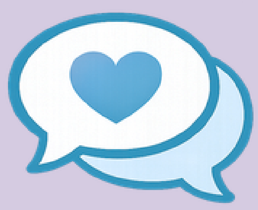
- “What’s your relationship with substances been like lately?”
- “What do you notice about when it feels helpful and when it feels harder?”
- “What would make it easier for you to reduce your use?”
- “On a scale of 1 to 10, how ready do you feel to make any kind of change, even a small one?”
  - “What makes it that number and not a lower one?”
  - “What might help move it up, even a little?”
  - “If you ever decided to make a change, what might feel like a doable step?”

Example MI aligned language related to GBV

- “Many people describe control rather than arguments. Does that resonate with your experience?”
- “Sometimes small behaviours add up. How do these moments affect your sense of freedom or safety?”
- “You’ve been doing what you need to survive. We can look at options together at your pace.”

This language intentionally:

- Avoids legal labels unless the survivor uses them.
- Validates ambivalence and protective choices.
- Supports disclosure without pushing action.



BRIEF INTERVENTION

Structured peer-led groups, meetings, or events provide opportunities for connection, shared experiences, and mutual support, which are identified as extremely helpful.

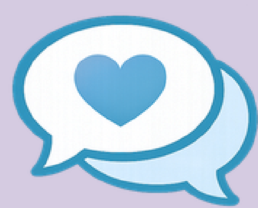
Jackson, S. (2025). Navigating Mental Health Services as an (Im)Perfect Service User. Journal of Psychiatric and Mental Health Nursing. https://doi.org/10.1111/jpm.70001
Aktas, M.C., Ayhan, C.H. (2025). Treatment experiences of women diagnosed with substance use disorder in eastern Turkey: A qualitative study. International Journal of Social Psychology 71(2) 264-273. DOI: 10.1177/00207640241300967

EQUIP TVIC — Micro-prompts (Brief Intervention)

- **Awareness:** “It makes sense to use what helps you get through. We can look at where it helps and where it costs.”
- **Safety & Trustworthiness:** “We can go at your pace. There is no pressure to make decisions today.”
- **Choice/Collaboration/Connection:** “Of the options we discussed, which—if any—fit for now?”
- **Strengths & Skill-Building:** “You’ve already been finding ways to get through. Would it feel helpful to build on that with a small safety step or grounding practice this week?”

10.12 TRAUMA-INFORMED BRIEF INTERVENTIONS

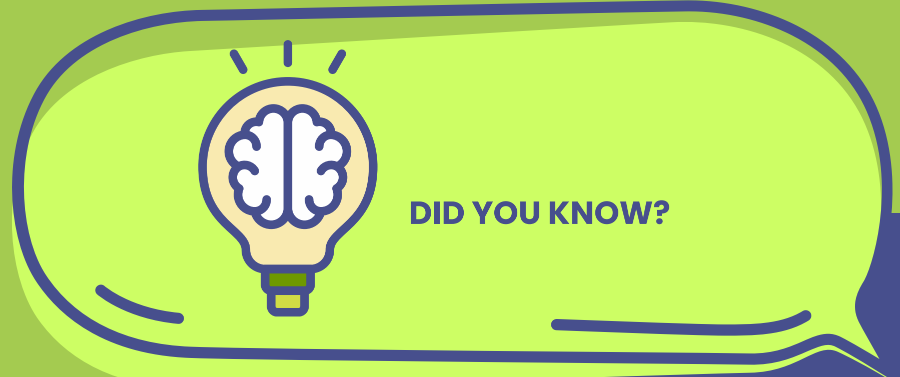
- Recognize the impact of trauma and avoid re-traumatization (SAMHSA, 2009).
- Core principles: Safety, trustworthiness, collaboration, empowerment, and cultural and gender sensitivity (SAMHSA, 2009).
- Often delivered in short sessions that focus on coping strategies, grounding techniques, and emotional regulation (SAMHSA, 2009).



BRIEF INTERVENTION

There is one vital question that all clinicians need to ask themselves at the outset: “Will my intervention leave this woman and her children in greater safety or greater danger?”

George, S., Boulay, S., & Galvani, S. (2011). Domestic abuse among women who misuse psychoactive substances: An overview for the clinician. Addictive Disorders & Their Treatment, 10(2), 77–87. https://doi.org/10.1097/ADT.0b013e3181ed0978



Police presence reduces the likelihood of GBV and/or substance use disclosure.

Kasseri, Z. (2025). Disclosure of problematic substance use and intimate partner violence: An exploratory study in Greece. Journal of Social Work Practice in the Addictions, 25(3), 316–330. https://doi.org/10.1080/1533256x.2025.2488818

Practice Takeaways

- **It is not appropriate to engage in memory-focused trauma work with women who are still being retraumatized (Bailey et al., 2020). Early trauma-informed care should instead focus on emotional, psychological, and physical safety, using approaches that do not require women to re-experience, recall, or describe traumatic events in detail, thereby reducing the risk of triggering victimization or a return to substance use.**

- **For women experiencing GBV, trauma symptoms can shift quickly depending on what is happening around them. Adding short, ongoing check-ins or between-session monitoring—reflecting how symptoms appear in daily life—helps providers better understand how symptoms change and how they relate to coping. This fuller understanding supports more personalized, balanced, and adaptable treatment plans, including coping skills and resilience strategies that women can use every day (Kiefer et al., 2024).**

- **PTSD in women often develops from repeated, relational, or emotionally damaging forms of abuse rather than from a single severe incident (Cleary & Hungerford, 2015).**

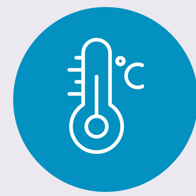
TRAUMA-INFORMED GROUNDING EXERCISES

Five Senses Check-In

Name five things you see, four you can touch, three you can hear, two you can smell, and one you can taste.

Deep Belly Breathing

Breathe in through your nose for four seconds, then out through your mouth for six seconds.



Temperature change (Cold Focus)

Hold something cool, such as a cold drink, a metal object, or a chilled cloth.

"Feet on the Floor" Grounding

Press your feet gently into the floor and notice the contact points.

Object Focus (Grounding Tool)

Hold a small object and focus on its characteristics.

PRACTICE PEARL: Responding to Disclosure

When they tell you, tell them you believe them, take them seriously, and stress that you do not see it as their fault and that you appreciate how difficult it can be to talk about it. Do not rush them into solutions or tell them what to do. This is what the person using abusive behaviours will likely have done.

George, S., Boulay, S., & Galvani, S. (2011). Domestic abuse among women who misuse psychoactive substances: An overview for the clinician. Addictive Disorders & Their Treatment, 10(2), 77–87. https://doi.org/10.1097/ADT.0b013e3181ed0978

Trust is an intervention.

For Black women, historical and ongoing harms within policing and healthcare systems shape how safety and help-seeking are experienced.

Effective IPV responses prioritize relational safety, cultural humility, and consistency rather than relying solely on procedural or reporting-driven approaches.

Richer, A., Goddard Eckrich, D., Chang, M., Wu, E., West, B., ElBassel-Bassel, N., & Gilbert, L. (2025). Patterns of intimate partner violence among Black women in community supervision programs who use drugs: A latent class analysis. *Health & Justice*, 13(38). https://doi.org/10.1186/s40352-025-00347-

BRIEF INTERVENTION

Did you know? iHEAL (Intervention for Health Enhancement After Leaving) is a culturally grounded program developed with Indigenous women that supports healing after leaving violence. It centres culture, community, and holistic care, reflecting strengths-based and reconciliation-informed approaches to GBV and substance-use support for Indigenous women and children.

Varcoe, C., Browne, A. J., Ford-Gilboe, M., Dion Stout, M., McKenzie, H., Price, R., Bungay, V., Smye, V., Inyallie, J., Day, L., Khan, K., Heino, A., & Merritt-Gray, M. (2017). Reclaiming Our Spirits: Development and pilot testing of a health promotion intervention for Indigenous women who have experienced intimate partner violence. Research in Nursing & Health, 40(3), 237–254. https://doi.org/10.1002/nur.

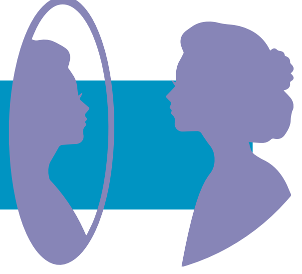
CONTINUUM OF SUBSTANCE USE IN GBV CONTEXTS — STRENGTHS-BASED, RELATIONAL PRACTICE (EQUIP / CEWH / TVIC-ALIGNED)

Use this table to guide trust-building conversations about substance use across a continuum and to recognize and respond to GBV-related substance use coercion. It aligns with EQUIP principles (awareness; safety and trustworthiness; choice, collaboration, and connection; and strengths and skills), CEWH resources, and Trauma- and Violence-Informed Care (TVIC).

Continuum stage	How this may show up (including GBV-related coercion)	Relational, strengths-based provider focus (EQUIP / TVIC)	Language to try (MI-aligned)	Substance-specific considerations
Beneficial / social use	Occasional or social substance use that fits within daily routines (e.g., having a drink with friends) and does not interfere with health, safety, or responsibilities. It may coexist with vigilance related to partners or family expectations.	Normalize universal inquiry; offer information only with permission; and affirm existing strategies that promote safety and connection. Emphasize choice, collaboration, and pacing.	"We ask everyone about safety and health, including substance use. Would it be okay if we talked about what alcohol, cannabis, or other substances do for you and what you might like to keep or change, if anything?"	Alcohol and tobacco are socially accepted; however, providers should consider medication interactions (e.g., antidepressants and anxiolytics) and context-specific risks such as driving or injury.
Episodic or experimental use	Substance use may be infrequent or situational (e.g., cannabis use on weekends). Safety concerns may also arise in specific contexts, such as travelling, driving, or unfamiliar settings.	Check safety with consent; explore context, strengths, and supports; and avoid labels. Reinforce autonomy and small, practical choices that fit daily realities.	"Would it help to look at any safety adjustments that matter to you, such as avoiding mixing substances with certain medications or planning a safe ride home?"	Cannabis: Effects on sleep, anxiety, and memory vary. Potency and legal context also matter, and discussions should include driving safety and timing.
Risky use	Patterns of substance use may increase the risk of harm (e.g., binge drinking after conflict or taking more medication than prescribed). Coercion may include pressure from a partner to use substances or exceed prescribed doses.	Explore what the substance helps with and where it creates challenges. Use collaborative brief interventions, Motivational Interviewing (MI), harm-reduction strategies, and safer-use planning. Emphasize connection and consent.	"Sometimes people use substances more often after stressful or frightening events. What does it help with most? What small change, if any, would feel doable this week?"	Alcohol and sedatives may interact with antidepressants and anxiolytics. Benzodiazepines may also be monitored or controlled by others; therefore, providers should discuss safe storage and privacy.

Continuum stage	How this may show up (including GBV-related coercion)	Relational, strengths-based provider focus (EQUIP / TVIC)	Language to try (MI-aligned)	Substance-specific considerations
Harmful use	Impacts may be emerging in health, relationships, employment, or housing. GBV-related coercion may include withholding medications, sabotaging recovery efforts, or using threats related to substance use.	Affirm efforts to cope and prioritize safety and trust. Offer harm-reduction options and safety planning, including overdose prevention, and provide warm, choice-based referrals. Encourage peer support and plan follow-up.	"Sometimes partners control medications or make it harder to access care. Has anything like that been part of your situation?" "What would a little more safety look like this week?"	Opioids, benzodiazepines, alcohol, and tobacco are associated with escalating health risks when use is sustained. Consider naloxone, safer-use supplies, and medication safeguards.
Substance use disorder	Persistent patterns of substance use may feel difficult to change despite significant impacts. Coercion can include forced use, threats related to treatment, or interference with opioid agonist therapy (OAT) or medication pick-up.	Emphasize dignity, hope, and partnership. Support access to integrated, gender- and trauma-informed care; coordinate warm transfers; protect privacy; involve peer support; and pace interventions according to readiness.	"You know your life best. If it helps, we can make a plan together, at your pace, for supports that feel right, including options that do not require stopping substance use. Would a warm introduction to a service or peer worker be helpful, or would you prefer to explore options first?"	Opioids, benzodiazepines, alcohol, and tobacco are associated with escalating health risks when use is sustained. Consider naloxone, safer-use supplies, and medication safeguards.

Practice reflection



✓ Ask with permission

✓ Listen for strengths and coping

✓ Consider safety, trauma, and coercion

✓ Offer options, not ultimatums

✓ Support choice, dignity, and connection

Remember: Trust is the intervention.

SUBSTANCE-SPECIFIC NOTES: SUPPORTING CONVERSATIONS ABOUT SUBSTANCE USE, SAFETY, AND COERCION

Examples of considerations and strengths-based conversation starters to support relational, trauma- and violence-informed discussions with women experiencing substance use and gender-based violence.

SUBSTANCE	CONSIDERATIONS IN GBV & COERCION CONTEXTS	SUPPORTIVE, MI-ALIGNED LANGUAGE TO TRY
Opioids & benzodiazepines (prescribed or not)	• Overdose and medication interaction risks • Partner control, theft, or diversion of medications • Interference with OAT or medication pick-ups • Withdrawal-related safety concerns • Need for secure storage and privacy for medications	Try asking... "Some partners control or take medications—has that happened here?" "Would it help to plan how and where to store meds safely, or talk about options like supervised dosing?"
Cannabis	• Effects differ (sleep, anxiety, attention) • Legal context and potency matter • Safety issues include driving and childcare timing • Check for pressure or rules set by others around use	Try asking... "What do you notice cannabis helps with most?" "Are there times when it gets in the way of what matters to you?" "Would you like to plan the timing or setting so that it feels safer?"
Tobacco / nicotine	• Common coping strategy • Stress-sensitive cessation or reduction may fit better than abstinence-only approaches • Restrictions on cigarettes may be used as a form of control (e.g., conditional access to cigarettes)	Try asking... "What would make smoking breaks feel calmer or safer?" "Interested in options like NRT or cutting back in ways that fit your day?"
Alcohol	• Highly prevalent and normalised • Interaction with antidepressants/ anxiolytics • Injury risk in conflict • Check for pressure to drink or for retaliation if not drinking	Try asking... "When is alcohol most helpful, and when is it least?" "Would it help to consider safer-drinking ideas or alternatives for those times?"

Principles

Safety first, always

Consent-led and supportive of choice

Predictability to build trust

Neutral documentation

Walking together

Removing barriers

Follow-up

10.13 REFERRAL TO SUPPORT AND SERVICES GUIDANCE:

Providing support and information about locally available resources and services is a key component of referral to supports. Service providers are encouraged to become familiar with locally available GBV and substance use services that clients can access.

Whenever possible, referrals should prioritize programs and services that address both GBV and substance use, or that are evidence-informed in supporting people experiencing both.

REFERRAL

IPV and substance use (SU) screening should include referrals to specialist services.

Kasseri, Z. (2025). Disclosure of problematic substance use and intimate partner violence: An exploratory study in Greece. Journal of Social Work Practice in the Addictions, 25(3), 316–330.
Jackson, S. (2025). Navigating Mental Health Services as an (Im)Perfect Service User. Journal of Psychiatric and Mental Health Nursing. https://doi.org/10.1111/jpm.70001
Aktas, M.C., Ayhan, C.H. (2025). Treatment experiences of women diagnosed with substance use disorder in eastern Turkey: A qualitative study. International Journal of Social Psychology 71(2) 264-273. DOI: 10.1177/00207640241300967

Intersectoral collaboration and integrated care are essential approaches for providing effective support when addressing GBV and substance use.

Myers, B., Carney, T., Johnson, K., Browne, F. A., & Wechsberg, W. M. (2020). Service providers' perceptions of barriers to the implementation of trauma-focused substance use services for women in Cape Town, South Africa. International Journal of Drug Policy, 75, 102628. https://doi.org/10.1016/j.drugpo.2019.102628

SUBSTANCE USE (SU)

IPV & DV

TRAUMA

TRAUMA-INFORMED SUPPORT

10.14 EVIDENCE-BASED MODELS AND PROGRAMS FOR GBV AND SUBSTANCE USE

- **Seeking Safety** focuses on coping skills for trauma and substance use.
- **Helping Women Recover and Beyond Trauma:** Gender-specific programs that integrate substance use and trauma recovery.
- **Trauma Recovery and Empowerment Model (TREM):** A group-based intervention for women with co-occurring disorders (Covington, 2008).
- **Return to Use Prevention and Relationship Safety (RPRS):** A group-based, evidence-informed intervention consisting of 11 two-hour group sessions and one individual session, designed specifically for women who experience both IPV and substance use (SU) concerns (Gilbert et al., 2016). It is guided by empowerment and social cognitive theories (Gilbert et al., 2016).
- **Strong Women:** The Strong Women intervention weaves together several evidence-based approaches that address gender-specific needs in recovery, such as emotion-focused, somatic, nature-based, self-compassion, and empowerment-oriented approaches (Brabete et al., 2024).
- **Hope & Recovery Program (The Jean Tweed Centre):** A three-week, group-based daily program that integrates skills-based psychoeducation, one-to-one counselling, and case management support, grounded in trauma-informed and gender-responsive approaches for women with experiences of GBV and substance use.

Feedback from a Participant in Jean Tweed's Hope and Recovery Program:

"I would not be here if it wasn't for the support I received. It helped bring me back. I believe that it saved my life because it was there for me when I was going through hard times. It helped me to feel like a human being again. I received support, and the counsellor never gave up on me. I'm still working on my healing, and there are many more people out there like me who need help."

10.15 REFERRAL TO SUPPORT AND SERVICES: KEY CONSIDERATIONS

Refer clients to programs where providers are trained in trauma-informed and gender-responsive care. Wherever possible, services should be integrated through partnerships or collaboration (e.g., substance use, GBV, mental health) rather than siloed approaches.

Peer and Community Support

Creating opportunities for peer connection and women-only environments can help reduce feelings of isolation and counteract stigma. These spaces allow women to share experiences with others who understand substance use and GBV-related challenges, strengthening engagement and emotional safety (Canadian Centre on Substance Use and Substance Use Disorder, 2020).

PRACTICE PEARL:

Trauma-informed documentation and care involve moving away from labelling clients as “non-compliant”, “not ready”, or “she doesn’t want our help”, and instead focusing on framing interactions through a neutral lens. Rather than attributing intent or motivation, it is more supportive for service providers to prioritize building rapport and ensuring safety, while remaining open to adapting their approach to better support the individual. Approaching clients with curiosity, flexibility, and patience, and showing up consistently, can help foster a sense of safety and shift how they experience the support being offered.

Ayodeji, M. (2025). Trauma-Informed Care in Substance Abuse Treatment: A Systematic Review of Public Health Strategies for Survivors of Gender-Based Violence in the United States. Current Journal of Applied Science and Technology 44 (4):143-52. https://doi.org/10.9734/cjast/2025/v44i44520

Housing and Safety Needs

When arranging referrals, it is essential to assess a woman's housing stability, including any risks of precarious, unsafe, or inadequate housing. Many clients benefit from referrals to women's shelters, family shelters, and GBV-specific housing programs, which may be necessary to address immediate safety and stabilization needs. It is also important to recognize that access to appropriate housing can be limited by systemic barriers, including limited availability, eligibility criteria, and safety concerns. Ongoing advocacy and flexibility may be needed to support women in navigating these challenges.

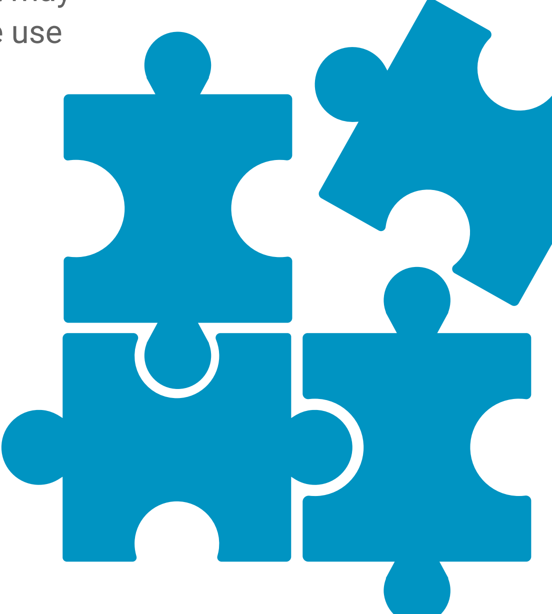
Follow-Up After Referrals

Research shows that simply making a referral does not guarantee that a client will be able to access or stay connected to a service (Dauber et al., 2019). Because of this, providers should proactively check in to see whether the person was able to connect with the service, troubleshoot barriers, and offer additional support as needed (Hill et al., 2024).

Why These Interventions Matter

Women who experience GBV and substance use face compounded risks, including mental health disorders, overdose, and barriers to care (Harm Reduction International, 2019). Evidence shows that brief, integrated, and trauma-informed interventions improve engagement and outcomes (Harm Reduction International, 2019).

Strong working partnerships may lead to increased cross-agency referral systems and case consultations, the development of formal service linkage policies, and the creation of coalitions or committees that may enhance services for people with co-occurring IPV and substance use disorders (Stone et al., 2022).



System Collaboration – Practice Tips

Identify a liaison or team lead to coordinate and maintain cross-sector relationships.

Hold regular cross-sector check-ins or case consultations, both virtually and in person.

Sample SBIRT step-by-step approach in action: incorporating a relational, trust-building approach.

Prepare (1 minute):
Ensure privacy and explain your role and the limits of confidentiality. Normalize universal questions (e.g., "We ask everyone about safety and health, including substance use").

Ask & Listen (LIVES + MI):
Begin with least-intrusive prompts. Listen without judgment, reflect values and hopes, and invite choice about what to explore now.

Spot & Respond Across The Continuum:
Use signs and impacts and continuum call-outs to recognize patterns—from episodic to risky or increasing harmful substance use and substance use disorder —without labelling or pathologizing.

Micro-Steps (Brief Intervention):
Co-create one small, meaningful step (e.g., a safety micro-tweak; a grounding skill; a peer connection; a shorter follow-up).

Safety & Warm Referrals:
Integrate safety planning, including overdose prevention. Offer warm transfers and, when possible, peer accompaniment to reduce retelling.

Collaborate Across Systems:
Map contacts in GBV, housing, primary care, harm reduction, child welfare, and legal services. Use warm hand-offs and shared planning with consent.

Document With Care:
Name coercion and context; record strengths and protective actions; and link symptoms to safety and environment. Keep records privacy-aware.

Care For Self & Team:
Debrief, reflect on biases, and use supervision. Sustainable, relational practice supports better outcomes for both women and providers.

10.16 WARM REFERRAL PATHWAYS

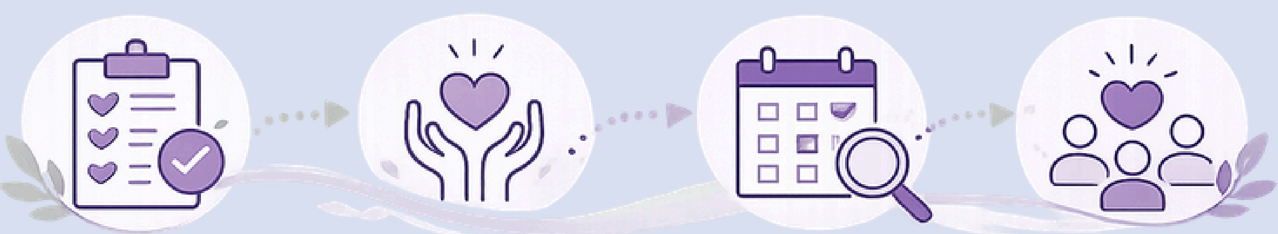
Why Warm Referrals Matter

For women navigating GBV and substance use (SU), a referral is not just a phone number; it is a bridge that must feel predictable, private, and consent-led. This is especially important because there are many “levels” of services that, in fact, involve multiple sectors, including peer support and community services, as shown in the figure below.

Warm referrals are a critical component of safe, trauma-informed care. They reduce retraumatization, improve follow-through, and enhance safety by actively walking alongside a woman until she feels welcome, connected, and oriented for the next service. This approach to TVIC centres safety, trustworthiness, choice, collaboration, and strengths-based support at every step.

Warm referrals are essential when substance use coercion is present, including pressured or forced use, threats of disclosure, or treatment sabotage. In these contexts, safety can change rapidly, and standard handoffs can increase risk and disengagement. A TVIC-aligned approach prioritizes privacy, communication safety, and pacing throughout the referral process to ensure continuity and protect safety.

Principles That Guide Every Warm Referral



Consent-led and supportive of choice. We ask for permission at each step, offer options (including not proceeding), and confirm which information she agrees to share.

Safety first, always. Start with a privacy check, confirm safe phone numbers and email addresses, and plan around surveillance, transport control, or medication interference.

Predictability builds trust. Explain roles, limits, and what will and will not happen next; avoid surprises.

Document neutrally. Record patterns (e.g., coerced use, control of medications or identification), protective actions, and the woman's goals; store only what is necessary for continuity and safety.

Walk together. A warm referral is a "three-way" connection (with consent), not a list. We stay until the first step is secured and a reconnection plan is established.

A THREE-PHASE WARM REFERRAL PATHWAY (STEP-BY-STEP)

PHASE 1: BEFORE WE REFER—PREPARE WITH CONSENT AND SAFETY

Privacy & role/limits.

"Is this a good time and place to talk? I want to explain my role, what I can and cannot do, and how we can decide next steps together."

What matters most today.

Briefly reflect on what is helping and what is costing (e.g., sleep, pain, safety, parenting pressures); acknowledge that substance use may be coping; avoid labels.

Screen for substance use coercion (consent led).

"Sometimes partners pressure or control substance use or medications, or sabotage treatment. Has anything like that been happening?" (Offer safer-use or medication-privacy tips as needed.)

4

Consent scope & safe communications.

Confirm what can be shared, with whom, and how you will communicate (no voicemail or text unless agreed; code words when needed).

Choose the next step together.

Offer two or three service options that match her goals (women-only, Indigenous-led, perinatal/family-centred, peer-led, harm-reduction services).

PHASE 2 — DURING THE REFERRAL: WARM CONNECTION, NOT A HAND-OFF

Three-way contact.

With consent, call the receiving service together, introduce yourself, and ask for the intake contact by name (where possible). This aligns with health sector protocol guidance for survivor-centred warm referrals.

Share the **minimum** necessary (e.g., "safety concerns, possible substance use coercion, preferred name and pronouns, access needs, and safe callback times"). Avoid retelling traumatic experiences in detail.

2

Reduce practical barriers.

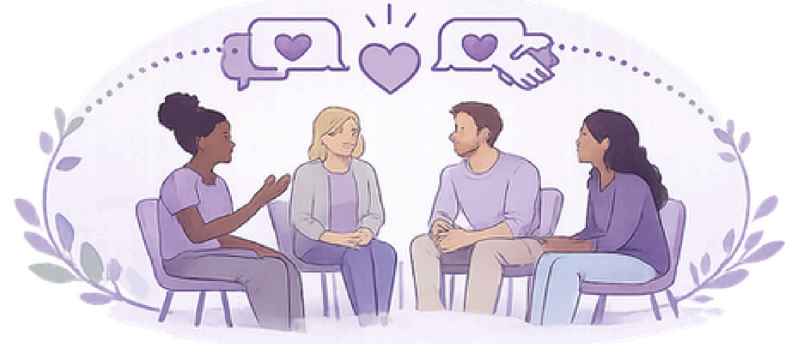
Confirm the first safe time; discuss transport, childcare, and identification; and ask about harm reduction (e.g., naloxone, opioid agonist therapy if applicable) or safety planning supports.

3

Set the reconnection plan.

Agree on how you and the receiving service will each follow up (who, when, and by what safe method), and how the woman can reach you if plans change.

Participants in a group intervention by Choo et al. (2016) found that people wanted the intervention to connect them to real people, especially peers experiencing substance use and/or IPV, and valued the human connection of people with lived experience.



Choo, E.K.. Gutfvia, K. M.. Midlo, M.. J. Wetle, T F... Banney. M. L. Tape. C.. & Ziornick. C. :2018) Il need to hear from women who have been there ': Developing a woman focused intervention for drug use and partner violence in the emergency department:.
Parmer Abuse, 7(9). 193--220l httos //dol org/10.16.11/1946-636017.2 193

PHASE 3 — AFTER THE REFERRAL: CLOSE THE LOOP AND PROTECT SAFETY

Neutral documentation.

Capture: (a) consents given; (b) patterns (coercion, medication control, transport control); (c) protective actions; (d) what matters most; and (e) next contact plan. Avoid judgment.

Check-in at the agreed time.

A brief, consent-led check-in signals reliability and can troubleshoot transport, scheduling, or new safety concerns **at the agreed time.**

If the step didn't happen.

Normalize; revisit barriers (privacy, surveillance, fear of child welfare), and re-offer low-threshold or anonymous supports (e.g., hotlines/crisis lines). Offer low-barrier, easy-to-access, or anonymous supports (e.g., hotlines or crisis lines).

Safe Information Sharing and Confidentiality

- **Only share** what she consents to and what is needed for safety and continuity; confirm who can access records.
- Use **women's words** where possible; avoid pejorative terms; and never downplay risk signals (e.g., signs of strangulation, escalating control).
- For trafficking risk, stick to **minimum first-line support (LIVES)** and safe options; do not press for disclosure; and avoid actions that could compromise safety.