CHAPTER 9

Rapid Evidence Synthesis: Key Themes From The Literature Reviewed

9. Rapid Review Evidence Synthesis: Key Themes From The Literature Reviewed

The following section summarizes the key themes that emerged from our rapid review of both grey and peer-reviewed academic literature. It builds on the material and evidence synthesized in the toolkit's background section and highlights findings from the data extraction table in the Appendix.

9.1 LINKS BETWEEN ADVERSE CHILDHOOD EXPERIENCES (ACES) AND TRAUMA WITH GBV AND SUBSTANCE USE:

ACEs and other early traumas can shape health, coping, and relationships across the life course. In adulthood, this may present as an increased risk of GBV and substance use as a way to manage fear, pain, and sleeplessness. Rather than interpreting these patterns as failure, we understand them as adaptations that made sense in context—and we respond with curiosity, consent, and care. Routine, brief questions about adversity and safety can help tailor support without requiring disclosure or detailed histories. The aim is to reduce re-telling, normalize coping, and open low-barrier pathways toward greater stability at the person's pace.

Reflections From a Jean Tweed Client

"I felt comfortable enough to share one of my earliest traumatic experiences with my counsellor. She helped me reconnect with myself as a child and imagine approaching and hugging that younger version of myself, while reminding her that she is deeply loved and brave."

9.2 TRAUMA- AND GENDER-INFORMED APPROACHES TO SERVICES AND PROGRAMS MATTER:

When life is unstable, expecting someone to be "ready" can close doors. Trauma- and gender-informed services meet women where they are, make processes predictable, promote choice, and focus on one small step that feels manageable this week.

Because substance use may be a trauma-linked coping strategy or shaped by coercion, we avoid labels and pressure and instead prioritize her goals—from safer use and better sleep to a warm call with an advocate to returning when conditions feel safer. Boundaries and consistent follow-up help build trust, while early practical skills such as grounding and safety planning can begin before intensive therapies.

Service providers and care workers must recognize that the lives of the women they support may at times be complex and unstable, which can affect their ability to participate in programs and services fully.

This means we should stop expecting women to be "ready" or a perfect fit for programs and instead accommodate their circumstances, make adapted services more accessible, and support re-entry into programs as their situations stabilize. This is especially important because trauma, coping, GBV, and substance use are closely interconnected (Jackson, 2025).

It is also important to recognize that substance use often occurs as a coping response to GBV or results from coercion or victimization (O'Brien et al., 2016). As a result, experiences of GBV may trigger a return to use or unpredictable increases in substance use.

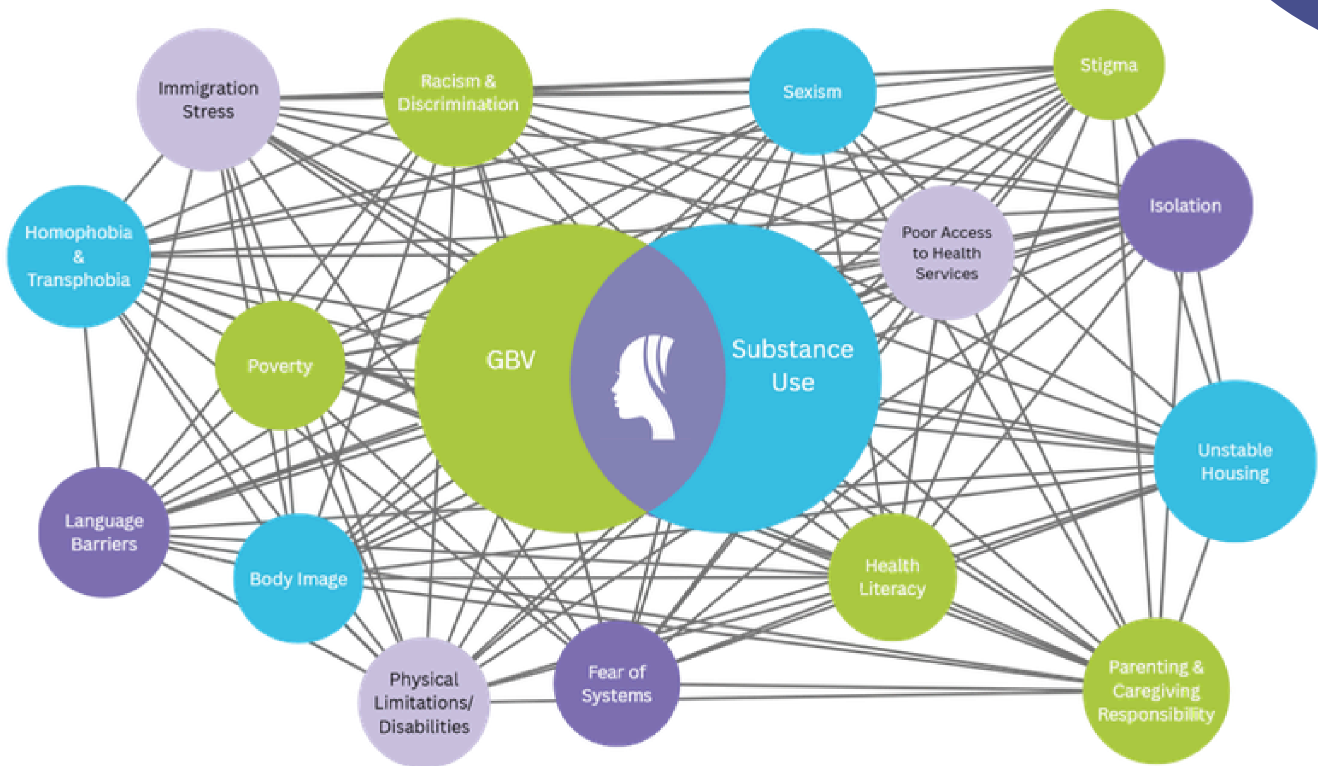
Respecting women's autonomy and supporting their ability to make their own choices are essential components of trauma-informed practice and help ensure that services remain collaborative and empowering (Hovey et al., 2020).

Providing services that recognize and respond to the effects of trauma can reduce the likelihood of renewed substance use and decrease the risk of women experiencing additional harm, while also helping them build confidence and feel safer (Edwards et al., 2023). Introducing trauma-related supports early in treatment is associated with improved outcomes; however, the level of intervention should match a woman's readiness. For some, beginning with basic grounding or stabilization strategies may be the safest and most effective starting point (Armstrong, 2023).

Debriefing and follow-up support are important when unexpected situations trigger past trauma. Because trauma often involves boundary violations, maintaining consistent and healthy boundaries is essential to creating a sense of safety in therapeutic environments (McGeown et al., 2023).

Supporting women in their recovery requires interventions that acknowledge how intimate partner violence can affect self-regulation, executive functioning, and relationship skills. Gender-responsive, trauma-informed, and relational approaches can help repair these developmental impacts, with strong therapeutic relationships playing a particularly important role in restoring emotional and cognitive regulation. These capacities can be strengthened through consistent routines, support with time management, calm and purposeful environments, opportunities to practice regulated interactions, and sensitivity to each woman's readiness and internal experiences (Motz et al., 2019).

9.3 INTERSECTIONALITY & SOCIAL DETERMINANTS:



Safety and substance use do not exist in a vacuum. Racism, poverty, housing insecurity, colonial harms, immigration-related stress, and minority stress can narrow choices and increase risk.

Viewing situations within their broader social and structural context helps avoid blame. It supports practical responses such as income and housing supports, flexible appointments, interpretation services, access to safer-use supplies, and advocacy across systems. An intersectional, feminist, and trauma- and violence-informed care (TVIC) approach helps keep services accessible, responsive, and relevant, especially for women facing multiple and intersecting barriers.

All sectors need to recognize that women's substance-use experiences vary widely. An intersectional lens helps us understand how gender and sex interact with factors such as race, class, and sexual orientation to shape women's overall health and social experiences (Harris et al., 2022).

A key part of applying intersectionality in policy is recognizing not only the individual vulnerabilities that can lead to discrimination but also the broader structural and group-based factors that contribute to marginalization (Dale et al., 2021).

Understanding how different forms of inequality overlap—and how they specifically affect women who use substances—helps clarify the gendered consequences of drug policies. This perspective can guide more effective strategies to prevent and respond to both HIV transmission and gender-based violence (United Nations [UN], 2023, p. 24).

Effectively responding to gender-based violence requires recognizing that people's experiences of violence are deeply shaped by the social and structural conditions in which they live (Wathen & Varcoe, 2019). Providers cannot offer meaningful support without acknowledging how inequities, poverty, and systemic violence influence survivors' everyday interactions with health and social services (Wathen & Varcoe, 2019). Trauma- and violence-informed care, cultural safety, and equity-oriented practices all depend on understanding these intersections and grounding responses in the real-life circumstances survivors face (Wathen & Varcoe, 2019).

When supporting women experiencing both gender-based violence and substance use, it is important to acknowledge how systemic issues such as poverty, racism, and housing instability shape their experiences and access to care (Mason & Toner, 2012). Research also shows that because many women face limited opportunities to change these structural conditions, recovery can be strengthened through empowerment-focused approaches—such as guided reflection and supported narrative work—which help build self-awareness and support healthier reinterpretations of their experiences (Alcantud et al., 2020).

UNDERSTANDING SUBSTANCE USE, GBV AND WOMEN'S EXPERIENCES

WHY THIS MATTERS

Substance use as coping

Many women use substances, including alcohol, tobacco, cannabis, and both prescribed and non-prescribed medications, to manage the impact of gender-based violence.

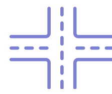
Increased vulnerability

Environments surrounding substance use often increase women's vulnerability, leaving them more likely to face poverty, social isolation, homelessness, and additional violence.
(Plaza-Hernández et al., 2023)

SHIFTING THE LENS

Feminist, Woman-centered Approach

- Violence is connected to wider social and economic inequalities.
- Not all personal failure
- Reduces guilt and supports understanding
- Creates space for safer choices and coping strategies. *(Benoit & Juffer-Trotter, 2015)*



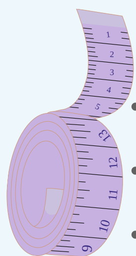
Intersectional Perspective

- People experience violence in different ways.
- GBV myths and stereotypes may cause the greatest harm
- Greater harm to marginalized women and gender-diverse individuals. *Scott et al., 2022*

Culture matters

- Culture can help people feel grounded and connected.
- Avoid linking violence to any culture
- Resist stereotypes or assumptions about communities *(Scott et al., 2022)*

SAFETY & RISK



Safety is not one-size-fits-all

- Risks and safety needs differ for each person.
- Shaped by overlapping identities
- Can shift over time

Systems matter in safety planning

Police

Child Protection

Immigration

Legal System

Systemic oppression and institutional actions can also increase danger
Scott et al., 2022

HOW SERVICES SHOULD RESPOND

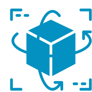
GBV services should be rooted in trauma- and violence-informed, feminist, and intersectional practices that recognize how individual harm is intensified by larger structural inequalities.

Within this Lens

Substance use and mental health issues are understood within broader experiences of marginalization, not moral failure.
(Dale et al., 2021)

Services Must Work Together

No two needs are the same. Programs and systems must collaborate across health, housing, justice, and public safety.



Responses Must Reflect Realities

Services should reflect the diverse realities of those they serve.
(Dale et al., 2021)

BIG PICTURE IMPACT

Financial insecurity

Intimate partner violence

Policies that address key social factors are essential in reducing the conditions that increase women's risk of substance use.
(DiMarco International, 2025)

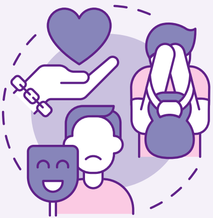
Sex and gender are key factors that shape health.

Biological sex influences susceptibility to certain health conditions, while gender- through social roles, expectations, and power inequalities- affects health in a way that changes over time, showing that gender is a dynamic, socially constructed determinant.
(Schamp et al., 2022)

The connection between substance use and GBV in women is complicated

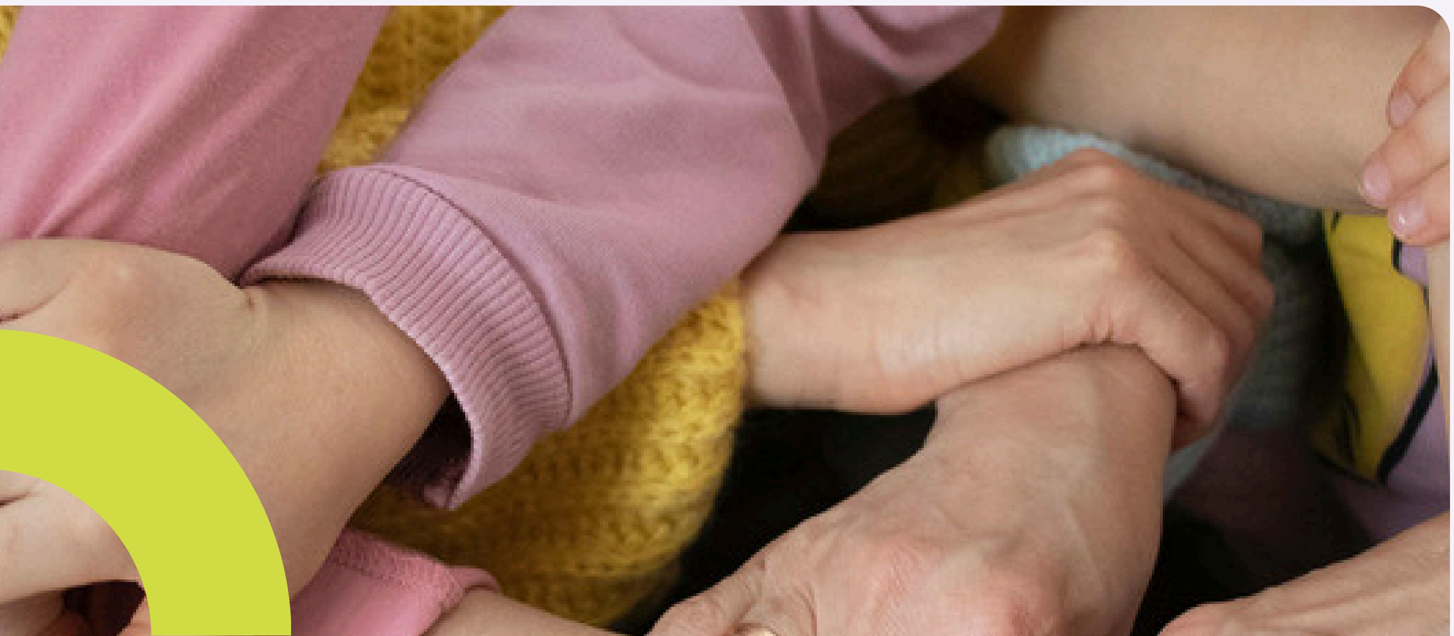
Understanding their overlapping, intersectional influences is essential in meeting women's needs effectively.
(Dillon,2025)

Women facing both GBV and homelessness often lack support across many areas, including financial resources, placing them among the most socially excluded groups. *(Kennedy et al., 2024)*



Those who are also navigating substance use encounter additional, overlapping challenges- such as codependency, coercion into illegal activities, stigma, and partners who control their substance use, which further limit their safety options and increase fear and barriers to seeking help.
Kennedy et al., 2024)

Existing research suggests that services frequently overlook or underestimate these complex realities, making it harder for women with addictions to access meaningful safety and care.
(Kennedy et al., 2024)



9.4 PEER SUPPORT AND LIVED EXPERIENCE:

Peers and women with living/lived experience make services more welcoming, responsive, and supportive. They help reduce shame, model hope, and assist women in navigating systems that can feel overwhelming. Where possible, organizations should co-design services with lived-experience advisors, compensate them for their contributions, and cross-train GBV and substance-use peer teams so that women do not have to bridge systems on their own.

Service providers are encouraged to prioritize survivors' perspectives and lived experiences, ensuring they can connect with peer networks and people with living/lived experience who provide survivor-focused support approaches (United Nations [UN], 2023). Connecting women to peer support networks is a powerful resource for many survivors.

- Actively involving women with living/lived experience of GBV and substance use in shaping, implementing, and evaluating services is crucial, as their participation strengthens program quality and contributes to improved outcomes for those who rely on these supports (Centre of Excellence for Women's Health, 2024; National Center on Domestic Violence, Trauma & Mental Health, 2022b; United Nations [UN], 2023). Examples of meaningful engagement include regularly seeking feedback about women's experiences with services and incorporating their input into service design and delivery through advisory panels, consultations, and other engagement opportunities. Wherever possible, honoraria should be provided to people with living/lived experience in recognition of their expertise, time, and contributions to service design and delivery.
- Peer-led approaches to programs and services help women build supportive relationships with one another and play a powerful role in fostering a sense of agency and empowerment (Centre of Excellence for Women's Health, 2024). Women consistently describe peer connections as reducing feelings of shame, offering encouragement, and providing meaningful support throughout their recovery journeys (Centre of Excellence for Women's Health, 2024).
- Peers help foster spaces where women feel emotionally safe, demonstrate that long-term recovery is achievable, and often view supporting others as an important part of their own healing journey (Centre of Excellence for Women's Health, 2024).
- Peer workers with specialized training in gender-based violence (GBV) can play a pivotal role in reducing service gaps by building trust, increasing women's sense of safety, supporting navigation through complex systems, and creating safer environments to discuss experiences related to substance use and GBV. This approach can help reduce the barriers that often prevent women from accessing the support they need (United Nations [UN], 2023).

Cross-Training for Peer Workers:

- Bringing GBV peers and substance-use peers together enhances collaboration.
- Joint learning helps teams better understand the intersection between IPV and substance use, shared challenges, and opportunities to coordinate services more effectively.
- Cross-training strengthens lived-experience-informed care and promotes a unified, trauma- and violence-informed approach (Stone et al., 2022).

Research indicates that support models combining peer involvement, trauma-informed practices, and flexible service delivery—particularly those tailored to women with low incomes—can significantly enhance mental well-being and improve access to essential supports and services (Matheson et al., 2015).

Safety Plan Practice Takeaways

- **privacy plan.** Identify safe times and places for calls, mail, appointments, and communication with providers.

- **Protect medications.** Safety plan for storing and accessing medications when a partner controls, withholds, or steals them, especially in cases of opioid agonist therapy (OAT), pain management, or recovery contexts.

- **Reduce visibility.** Explore ways to adjust appointment timing, location, or treatment modality if regular attendance increases the risk of stalking or monitoring.

- **Safeguard records**. Discuss who can access health records, insurance information, and electronic health records (EHRs), and take steps to limit unauthorized access.

- **Review legal control.** Identify legal documents (e.g., power of attorney) that may give a partner using abusive behaviours control over care, and plan to amend them.

- **Support continuity of care.** Strategize ways to remain in treatment when a partner pressures the survivor to stop.

- **Warm referrals matter.** Connect survivors to IPV-informed advocates and trauma- and substance-use-informed mental health providers who understand GBV dynamics.

- **Include childcare needs.** Ask what childcare supports are needed to access treatment, especially for inpatient or intensive options, safely.

9.5 FACTORS THAT FACILITATE ACCESS TO SERVICES AND REDUCE BARRIERS

Essential concrete supports—such as childcare, transportation, food and nutrition assistance, flexible scheduling, low-threshold entry, and warm transfers—can significantly improve access to services and expand what feels possible for women seeking support. Language also matters: providers can normalize check-ins about safety and substance use, avoid judgmental phrasing, and validate that coping strategies may have served an important purpose. Gentle awareness-building practices—such as noticing patterns and naming coercion—can help women identify what safety and support might look like for them in the present moment.

- Providing reliable childcare and transportation support can remove major barriers that prevent women who are parenting and experiencing substance use and/or GBV from accessing needed services, making it easier for them to engage in care (Warshaw & Tinnon, 2018). Such models are highly effective in reducing barriers to service access.

- Services should be free or genuinely affordable for women experiencing financial hardship.

- Women's substance use treatment and recovery programs that provide nutritional supports—such as prepared meals, grocery vouchers, food hampers, and nutrition-focused counselling to help meet basic needs and promote overall well-being—have been shown to facilitate access to services (Centre of Excellence for Women's Health, 2024).

- Providing hands-on support—such as "warm transfers" (actively ensuring referrals are made directly with follow-up) and service navigation (supporting connections to services outside one's sector)—helps women move between programs and systems more comfortably, reduces fears of being turned away, and lowers the risk of losing contact with services (Centre of Excellence for Women's Health, 2024). This approach includes stronger coordination between mental health and primary care providers, along with clear follow-up procedures that outline next steps, maintain continuity of care, and support long-term recovery and reintegration (Romo-Avilés et al., 2025).

- Offering women greater flexibility—such as adaptable appointment scheduling, women-only services, and prioritizing access for those experiencing GBV—has been shown to significantly reduce barriers to engagement with supports (Romo-Avilés et al., 2025).

- Adjusting appointment policies—such as allowing grace periods for late arrivals or adopting more flexible approaches to missed appointments—can help create a more accessible and accommodating service environment for women seeking support (Warshaw & Tinnon, 2018).

GBV supports must remain fully accessible to women regardless of substance use, as restricting services based on substance use further isolates survivors who already face significant barriers to safety and support (Zapata-Alma, 2020).

- Providing trauma-informed, integrated support—where staff work alongside women to help them recognize and manage triggers rather than isolating or separating them—is critical to ensuring that all survivors have equitable access to safety and care (Ontario Association of Interval & Transition Houses, n.d.).

- Many women face challenges accessing mainstream substance use or GBV services due to family expectations, cultural pressures, or safety concerns. These barriers can be reduced by offering low-threshold supports in settings women already access. This may include embedding GBV and substance use workers within familiar community programs and agencies, making it easier and safer for women to connect with support.

Many women describe how prolonged exposure to violence within families or relationships can make harmful behaviours feel routine or "normal." As a result, some may not initially identify their experiences as GBV, which can delay or prevent help-seeking (Kennedy et al., 2024). This underscores the importance of gentle awareness-building and clear psychoeducation to support earlier recognition of abuse and reduce barriers to accessing care (Kennedy et al., 2024).

Practice Pearl:
When providers gently identify harmful patterns without criticism and create space for women to reflect on their experiences, it can help women better understand their needs and feel more prepared to seek support (Kennedy et al., 2024).

A woman's decision to reach out for help is strongly shaped by how the first person she confides in responds (Alcantud et al., 2024). When she is met with empathy and understanding rather than judgment, it becomes easier for her to recognize what is happening, consider her options, and feel more confident in seeking additional support (Alcantud et al., 2024). Evidence shows that an empathic first response increases the likelihood that she will pursue further help. In contrast, many women fear that disclosing abuse will result in being pressured to leave the relationship or having their experiences minimized. Responses that attempt to direct her choices can mirror the control she already experiences, creating a major barrier to seeking support again (Alcantud et al., 2024).

9.6 SAFETY PLANNING:

Safety planning works best when it is practical, consent-led, and tailored to daily life. This may include identifying safe times and places to talk, protecting privacy around records and medications, planning for overdose risk, exploring options for housing and legal support, and developing code words or reconnection steps for virtual care. Safety planning should be approached as a form of harm reduction—supporting measures that help protect her safety today, whether or not larger changes are possible at this time.

Safety planning should take a **whole-life approach** by considering every aspect of a woman's daily environment, including her home, workplace, school, and community. It can also be integrated directly into a broader harm reduction strategy.

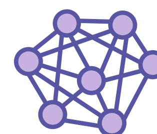
Safety planning should include **supportive counselling** to help women think through their safety options. It may involve connecting them with legal or financial guidance and assisting them in accessing additional supports, such as emergency shelters or housing services.

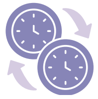
When supporting women who use substances, return-to-use prevention planning should also address **personal safety**, including strategies for coping with ongoing violence or victimization. It is important to recognize that reducing substance use can sometimes increase the risk of harm if abusive partners perceive their control as being challenged. At the same time, increased substance use may also heighten safety concerns. Exploring these possibilities collaboratively and developing a plan that prioritizes her safety at every stage is essential.

Safety plans should be **practical, achievable, and focused on immediate needs**. This includes identifying specific steps she can take, when and where she can take them, and who can support her. Plans should also reinforce the importance of meeting basic needs and incorporating self-care—such as sleep, nutrition, physical activity, healthy routines, and supportive relationships—as part of maintaining safety and stability.

It is important to keep safety planning **collaborative, simple, and paced to avoid overwhelming the client**. The goal is to support a sense of clarity and agency rather than create another layer of pressure.

It can also be helpful to distinguish between an **"immediate"** safety plan and a more **comprehensive** safety plan. An immediate safety plan focuses on what the client can use during moments of escalation, such as whom to call, where to go, or one or two grounding strategies. A more comprehensive safety plan can be developed gradually over time and may include longer-term considerations such as housing, financial planning, documentation, digital safety, and broader support systems.

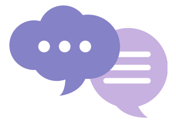




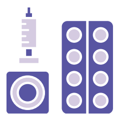
Framing safety planning as an evolving process allows the client to move at a pace that feels manageable while gradually strengthening their overall safety.

Effective safety planning may involve helping women gather essential documents, identify trusted people or organizations they can contact if they need to leave quickly, and set goals that do not necessarily involve leaving the abusive relationship—especially when substance use complicates the situation. Because substance use and GBV frequently co-occur, advocates need strong skills to develop safety plans that reflect each woman's unique circumstances, including substance use, trauma history, and mental health needs, and to identify which services and agencies are best equipped to support her.

Providers can also help brainstorm safer ways to store photos, messages, identification, and other forms of documentation that may become important for safety, legal, or support purposes (Reed, 2025).



Harm reduction principles can help guide conversations with women about what may support their safety in both their relationships and daily lives while also respecting their substance use goals and where they are in their recovery journey.



Harm reduction communicates that support remains available regardless of the choices women make or where they are in their journey. It does not require or prioritize abstinence above all else; instead, it emphasizes choice, dignity, and safety (BCSTH Staff et al., 2024).

Practice Pearl:

Some women may have difficulty concentrating during safety-planning conversations. These challenges may be related to mental health concerns, substance use, trauma, or other factors. As a result, information may need to be repeated, and safety planning may need to occur gradually over multiple conversations rather than within a single meeting. Additional approaches that may support women who have difficulty maintaining focus include:

- Meet in a private environment and be mindful of sensory stimulation that may affect concentration and memory.
- Ask whether she would like to take notes or write down key points, and support her in deciding where to safely keep those notes or how she would prefer to remember the information.
- Review and reinforce key ideas gradually and repeatedly over time.
- Ask what you can do to help her remain engaged and present during the conversation.
- Explore whether a different approach to discussing safety might work better for her (BSCTH Staff et al., 2024).

1. Normalize Safety Discussions

- When beginning conversations about safety, explain to clients that these discussions are routine and occur with everyone you work with (Hill et al., 2021).
- Ask the client whether it feels like an appropriate time to explore safety together (Hill et al., 2021).
- If the client appears hesitant or uncomfortable, this may suggest that someone unsafe is nearby or that the environment does not feel private enough for conversation (Hill et al., 2021).

2. Use a Compassionate, Non-Pressuring Approach

- Providers should remain empathetic and avoid encouraging clients to take steps before they feel ready (Salwen et al., 2016).
- Instead of urging immediate action, ask whether the client is open to hearing about available resources.
- Reinforce that even small safety improvements and basic education can play a meaningful role in supporting future choices (Salwen et al., 2016).

3. Keep Key Resources Easily Accessible

- Ensure that information on shelters, legal supports, and advocacy services is readily available so it can be shared quickly when needed (Mason & Toner, 2012; Public Health Nursing Practice, Research & Education Program [PHN-PREP], 2021).

4. Reinforce That Leaving Is a Process

- Normalize that leaving an unsafe relationship often occurs in stages (Reed, 2025).
- Many survivors leave and return multiple times (Reed, 2025).
- Emphasize that this is common and not a reflection of failure or poor judgment.
- Safety planning should remain flexible and responsive to the survivor's current situation and readiness (Reed, 2025).

5.Telehealth / Virtual Care Safety Strategies:

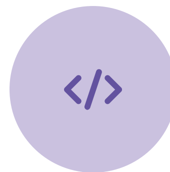
- Use subtle safety checks. If you are uncertain about the client's privacy or ability to speak freely, you can briefly display a written message on the screen, such as "Is this a safe time to talk?", to assess the situation without drawing attention from nearby others (PHN-PREP, 2021).

- Suggest the use of headphones. Wearing headphones can enhance confidentiality and reduce the likelihood that sensitive conversations will be overheard (PHN-PREP, 2021).

- Confirm that the timing still works. Ask whether it remains a safe and appropriate time for the appointment. Normalize rescheduling and avoid penalizing clients for missed or late appointments, as these may be related to immediate safety needs (PHN-PREP, 2021).

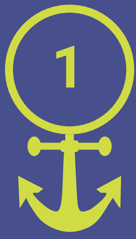
- Prepare for potential technology disruptions. Before beginning the session, discuss the steps to take if the call disconnects unexpectedly (PHN-PREP, 2021).

- Create a reconnection plan together. Decide who will initiate contact if the call drops and outline the next steps if reconnection is not possible. This may include using a different communication method, contacting a trusted support person (e.g., a family member, friend, or neighbour) to help ensure the client's safety, or relying on pre-agreed permission to contact emergency services if necessary (PHN-PREP, 2021).



- Establish a safety code word. Agree in advance on a word or phrase the client can use if their safety becomes compromised during the virtual session (PHN-PREP, 2021).

Four Anchors Approach — Micro-Prompts for Pregnancy and Parenting



Awareness:
"Parenting often occurs under significant scrutiny, and fear of systems can be very real."

Safety & Trustworthiness:
"Let's review confidentiality and your choices before we begin."

Choice/Collaboration/Connection: "What are your hopes for your children, and how can we align care with those goals?"

Strengths & Skill-Building:
Identify caregiving strengths and develop plans that support and protect parenting.

Safety Plan Practice Takeaways

Safety Plan Practice Takeaways

Do not initially refer to the partner's behaviour as GBV. Instead, use language such as inappropriate behaviour, unsafe behaviour, or possible abuse. Be careful about criticizing the partner. Women experiencing IPV may care for their partners and may become defensive or shut down if the partner is criticized.

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

9.7 CHILDBEARING AND PARENTING CONSIDERATIONS:

Pregnancy and parenting bring heightened scrutiny as well as important opportunities for support. Many parenting women fear that disclosure will lead to surveillance or child removal. We centre parenting strengths, clarify confidentiality, and connect women to supportive family members, close friends, chosen family, women-only services, and culturally grounded care.

- Service providers play a critical role in supporting the safety, health, and well-being of women who are pregnant, childbearing, or parenting while experiencing gender-based violence (GBV) and substance use. Pregnancy and parenting are periods of heightened vulnerability, but they are also important opportunities for engagement, trust-building, and early support. In Canada, failing to address the intersecting realities of violence, substance use, and parenting can unintentionally increase harm, reinforce stigma, and deter women from accessing care—particularly when services are perceived as judgmental or punitive rather than supportive (Wathen & Varcoe, 2019; CIHI, 2024).

- Women may avoid discussing how violence and/or substance use have impacted them because they fear that child welfare authorities may apprehend their children. These fears are well-founded. Canadian evidence shows that women who experience mental health challenges or use substances—especially during pregnancy or while parenting—are disproportionately surveilled and judged as “unfit” parents, despite actively taking steps to protect and care for their children (BC Society of Transition Houses, 2024; Public Health Ontario, 2023).

- This dynamic is further intensified in the context of GBV, where women may be held responsible for the violence they experience or penalized for coping responses, such as substance use. As a result, disclosure can feel unsafe, and service avoidance becomes a rational strategy for protecting both themselves and their children.

- Trauma- and violence-informed, culturally safe approaches that recognize substance use as a coping response—and parenting as a potential source of strength—are therefore essential to reducing fear, supporting engagement, and promoting family safety and stability (Wathen & Varcoe, 2019; Canadian Centre on Substance Use and Addiction, 2021).

- There is an elevated risk of violence during pregnancy and in the early postpartum period. These stages can be important opportunities for intervention, as family stress often increases during pregnancy and shortly after birth, which may contribute to increased violent behaviour (4).

- Women who use substances and are parenting are at significantly higher risk of child apprehension. They are six times more likely to have their children removed than substance-using fathers (2).

- Mothers who use substances also face elevated emotional and psychological strain. They are more likely to attempt suicide than women who use substances who are not parenting (2).

REPORTING OBLIGATIONS AND MAINTAINING TRUST

In Canada, there is no general mandatory reporting requirement for adult intimate partner violence (IPV) to police. However, specific legal duties do apply, particularly when children may be at risk. For pregnant or parenting clients experiencing gender-based violence (GBV) and substance use, transparency about reporting obligations is essential to maintaining trust, supporting informed choice, and reducing fear of systems involvement.

KEY LEGAL AND PRACTICAL CONSIDERATIONS

Adult IPV and Confidentiality

There is no general legal duty to report adult IPV to police in Ontario. Information should remain confidential unless another law applies, such as situations involving serious and imminent risk of harm.

When sharing information across sectors, use trauma- and violence-informed approaches and share only what is necessary.

Duty to Report Concerns About Children

Under Ontario's Child, Youth and Family Services Act (CYFSA s.125), anyone who has reasonable grounds to suspect that a child may need protection must report those concerns to a Children's Aid Society (CAS). This can include situations involving severe exposure to IPV/GBV, neglect, or unmet basic needs.

Mandatory reporting applies to children under age 16. For youth aged 16–17, reporting is discretionary, although CAS is still required to assess concerns brought forward.

A report to CAS initiates an assessment process and does not automatically result in the removal of a child.

Preventing Serious Harm

Ontario privacy law permits disclosure without consent when necessary to eliminate or reduce a significant risk of serious bodily harm. In these situations:

- Share only the minimum necessary information
- Document the rationale for disclosure
- Follow organizational policies and consultation processes whenever possible

Practice Considerations

Fear of systems involvement can prevent women from seeking support or speaking openly about violence and substance use. Whenever possible:

- Explain confidentiality and reporting obligations early
- Be transparent about what may need to be shared and why
- Involve the client in planning next steps whenever safety allows
- Reinforce that support and safety planning remain the priority

WHAT THIS MAY SOUND LIKE (MICRO-SCRIPTS)

Transparency Up Front (Building Trust)

"I keep what you share private. If I become concerned that a child may be at risk, or that there is a serious risk of harm, I may need to share limited information to help keep people safe. If that happens, I will explain what I am sharing and why, and we can discuss next steps together."

Before Making a CAS Report

"I am concerned your child may need protection, and the law requires service providers to contact Children's Aid. We can make the call together and talk about supports that may help keep your child safe. I will share only the necessary information. A call to CAS begins an assessment process and does not automatically mean child removal."

If Sharing Information to Prevent Serious Harm

"I am concerned there may be a significant risk of serious harm. Privacy law allows me to share only the minimum information necessary to reduce that risk. I will document what I share and why."

Did You Know?
Childbearing and Parenting

Parenting stigma is a barrier to safety and disclosure.

- Many women who are pregnant or parenting and experiencing GBV and substance use fear that disclosing their experiences will lead to surveillance, child-welfare involvement, or loss of custody.
- These fears are often well-founded and reflect systemic responses that disproportionately judge women who use substances or women affected by trauma as "unfit," rather than recognizing their protective efforts and caregiving strengths.

Instead of Asking: "Why didn't you leave?"

Ask This Instead: "What has helped you stay safe so far?"

Mason, R., & Toner, B. (2012). Making Connections: When domestic violence, mental health and substance use problems co-occur (Training manual). Women's College Hospital. http://dveducation.ca/makingconnections/pdf/making_connections_training_manual.pdf

CARE PRACTICES MATTER:

- Avoid assumptions about parenting capacity based solely on substance use or mental health concerns.

- Recognize parenting as a potential source of motivation, resilience, and safety-seeking.

- Use trauma- and violence-informed, culturally safe approaches that prioritize trust, choice, and confidentiality.

- How providers respond can influence whether a woman feels safe enough to engage—or chooses to avoid care altogether.

WHY THIS MATTERS FOR SERVICE PROVIDERS

Pregnancy and parenting are both high-risk and high-opportunity periods.

Women experiencing gender-based violence and substance use during pregnancy or while parenting may delay or avoid seeking help due to fears of judgment, child welfare involvement, or punitive responses. When services are perceived as unsafe or punitive, women may protect themselves and their children by remaining silent or disengaging from care.

What helps:

- Normalizing conversations about safety, substance use, and parenting as routine rather than suspicious
- Framing substance use as a coping response rather than a parenting failure
- Centring women's goals for their children within safety planning and care

Key message:

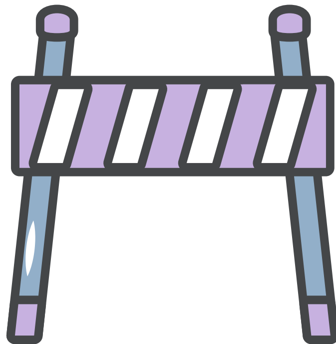
Supporting mothers with compassion, dignity, and respect strengthens — rather than undermines — child safety.

Parenting Capacity and Protective Factors: Do not assume that a parent who uses substances is incapable of parenting safely. Consider the full picture, including safety efforts, return-to-use prevention plans, and child protection strategies. Children may be removed due to GBV and, in some cases, returned to abusive partners because of the mother's substance use history.

National Center on Domestic Violence, Trauma & Mental Health. (2022, October 13). Substance uses 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/

PRACTICE IMPLICATIONS

- Approach conversations with empathy and awareness of the heightened fear, scrutiny, and stress that parenting women who use substances may experience.
- Create a safe, non-judgmental environment that reduces barriers to disclosure and support-seeking.



BARRIERS TO ACCESSING SERVICES

- Women experiencing both substance use and gender-based violence (GBV) during pregnancy or while parenting face multiple obstacles when trying to access support. These challenges include stigma, lack of childcare, and limited treatment programs designed specifically for pregnant or newly parenting women that address the intersecting impacts of GBV and substance use (5).
- Additionally, women may avoid seeking help because of the legal and social consequences associated with accessing substance use treatment while pregnant or while caring for children (11).

ASSESSING PARENTING CAPACITY

When evaluating a parent who uses substances, focus on their overall caregiving abilities and the protective strategies they have in place.

Avoid making assumptions that substance use automatically means a parent is unable to care for their children.

Instead, take a holistic view—consider the steps they take to keep their children safe and the strengths they demonstrate in their parenting.

Support parents by helping them develop return to use-prevention plans that also incorporate child-safety measures, ensuring both parental wellbeing and child protection are addressed together (19).

9.8 CULTURAL SAFETY:

The experience of the person receiving care defines cultural safety. We attend to power imbalances, racism, and colonial harms, and invite the involvement of Elders, language, and land-based practices where desired. Practitioners commit to self-reflection, use non-pathologizing language, and create spaces and processes that feel respectful, predictable, and collaborative.

- In the Canadian context, cultural safety is defined by the service user's experience of respect and power-sharing and requires attention to colonial harms and systemic racism in everyday practice (Wathen & Varcoe, 2019; First Nations Health Authority).
- Cultural safety refers to an approach to care that recognizes and actively addresses unequal power relations, systemic discrimination, and the ongoing impacts of colonialism and racism. It is defined by the service user's experience of feeling respected, safe, and free from discrimination within service settings (Government of Canada, 2018; Canadian Institute for Health Information [CIHI], 2024). Cultural safety is essential for service providers working with women experiencing gender-based violence (GBV) and substance use because it directly addresses the power imbalances, stigma, and systemic harms that often shape women's interactions with health and social service systems.

In the Canadian context, culturally safe, trauma- and violence-informed care helps prevent re-traumatization, strengthen trust and engagement, and improve access to support by recognizing how racism, colonization, gender inequity, and substance-use Stigma intersects to influence women's safety, help-seeking, and recovery outcomes (Wathen & Varcoe, 2019; Canadian Centre on Substance Use and Addiction [CCSA], 2021).

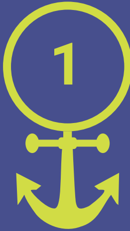
- Cultural safety matters because women experiencing GBV and substance use are more likely to disengage from services when care reproduces stigma, racism, or unequal power dynamics.

Culturally safe, trauma- and violence-informed approaches improve safety, trust, and access to support by recognizing the ongoing impacts of violence, colonization, and structural inequities within Canadian service systems (Wathen & Varcoe, 2019; CIHI, 2024).

Culturally tailored self-care strategies, such as spirituality, mindfulness, social support, help-seeking, and resilience, can strengthen coping.

Gilbert, L., Stoicescu, C., Goddard-Eckrich, D., Dasgupta, A., Richer, A., Benjamin, S. N., Wu, E., & El-Bassel, N. (2023). Intervening on the intersecting issues of intimate partner violence, substance use, and HIV: A review of Social Intervention Group's (SIG) syndemic-focused interventions for women. Research on Social Work Practice, 33(2), 178–192. https://doi.org/10.1177/10497315221121807

Four Anchors Approach — Micro-Prompts (Cultural Safety)



Awareness:
"Whose knowledge is guiding this conversation? What histories are shaping today?"

Safety & Trustworthiness:
"What would cultural safety look like for you in this space?"

Choice/Collaboration/Connection: "Who would you like involved (e.g., Elders, peers, or support people)?"

Strengths & Skill-Building:
"What practices help you feel grounded and strong?"

Service and Support Considerations

- **Need for Integrated Referral Pathways**

There is a clear need for coordinated referral systems that offer harm-reduction counselling, prenatal and postnatal supports, and programs that serve both mother and child. This should include access to parenting resources and attachment-focused interventions (1, 5).

- **Impact of Family-Focused Services**

Engagement in family-oriented services—such as parenting programs, GBV counselling, assertiveness training, life-skills development, family planning, and non-medical pregnancy supports—has been linked to reductions in substance use following treatment (16).

- **Benefits for Both Mother and Child**

Providing targeted services to pregnant and parenting women can improve outcomes for the entire family. These supports enhance parenting capacity and positively influence child development, consistent with the United Nations Office on Drugs and Crime (UNODC) International Standards on Drug Use Prevention (12).

Commit to self-reflection.

Cultural safety requires practitioners to continually assess how their personal beliefs and the dominant cultural narratives they have internalized—such as sexism or survivor-blaming views—may influence their work. Without this awareness, these biases can weaken empathy and contribute to interactions that are harmful rather than supportive to survivors (Cleary & Hungerford, 2015).

Respond to behaviour through a trauma-informed lens.

Culturally safe practice means valuing each person's cultural identity and understanding that behaviours sometimes labelled as "challenging" may often be expressions of trauma. Providers are encouraged to maintain professionalism and compassion by using team support, supervision, and collaboration to prevent burnout and reduce the risk of judgmental responses (Cleary & Hungerford, 2015).

Acknowledge the impacts of colonization.

A central component of culturally safe care is developing a strong awareness of colonial history and examining how it continues to shape current beliefs, practices, and service structures. Providers must actively avoid perpetuating colonial harms and work in ways that elevate the strengths, identities, and cultural perspectives of Indigenous survivors (Scott et al., 2022).

Create environments shaped by safety, not assumptions.

As emphasized by Wathen & Varcoe (2019), cultural safety is less about categorizing people by cultural traits and more about understanding how historical and ongoing trauma influence their relationships with services. The priority is to design interactions, policies, and systems that feel respectful, empowering, and safe for people from all backgrounds.

9.9 2SLGTBQIA+ INCLUSIVE APPROACH:

For many 2SLGBTQIA+ women and gender-diverse people, minority stress, economic precarity, and provider bias increase risk and deter help-seeking. We use affirming names and pronouns, maintain trans-inclusive referral pathways, and screen for GBV and substance use together using non-judgmental language. Safety planning includes gender-affirming items (e.g., clothing, medication), privacy considerations, and warm introductions to trusted services.

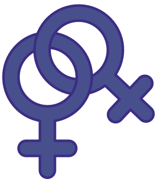
Four Anchors Approach – Micro-Prompts (2SLGTBQIA+ inclusive Approach)

1. **Awareness:** Minority stress and safety concerns shape help-seeking behaviours.
2. **Safety & Trustworthiness:** "What name and pronouns would you like me to use? Is this a safe time to talk?"
3. **Choice/Collaboration/ Connection:** "Are there any supports or people you would like us to involve or avoid?"
4. **Strengths & Skill-Building:** "What is already helping you feel safer and affirmed?"

A. KEY PATTERNS AND DISPARITIES (Why Inclusion Matters)

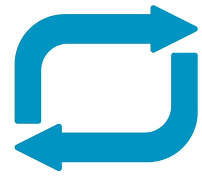
1. **Higher lifetime risk of GBV among transgender people.**
Transgender and non-binary individuals experience intimate partner and gender-based violence at rates approximately 1.7 times higher than cisgender individuals over their lifetime.

2. **Greater risk of alcohol use disorder.**
Sexual and gender minority populations face an increased likelihood of developing alcohol use disorder compared with the general population.



3. **Disproportionate sexual victimization among sexual minority women.**
Lesbian and bisexual women experience significantly higher levels of sexual violence. Bisexual women, in particular, report rates of rape and sexual assault that are more than ten times higher than those of both lesbian and heterosexual women.

4. **Patterns of revictimization.**
Among sexual minority women, repeated sexual victimization is associated with substance use, biased or discriminatory treatment, and additional forms of gender-based violence within family or community contexts.



5. **Minority stress and health impacts.**
Ongoing stigma and discrimination contribute to poorer physical and mental health outcomes for transgender emerging adults.

B. ACCESS AND SERVICE BARRIERS

1. **Provider-driven obstacles.**

Limited provider knowledge, lack of cultural responsiveness, and experiences of microaggressions, hostility, or refusal of care all create significant barriers to accessing services. Some transgender clients avoid formal supports entirely because of past negative experiences.

2. **Concerns about disclosure.**

Clients may hesitate to share experiences of GBV if they sense that providers are unfamiliar with 2SLGBTQIA+ issues, including abuse within same-gender relationships or the availability of affirming referral resources *(Ades, 2020)*.

C. SOCIO-STRUCTURAL CONTEXT

1. **Heightened economic and social precarity.**
Transgender individuals experience higher rates of employment discrimination, financial instability, and family rejection than the general population.

2. **Economic supports as safety tools.**
Material supports—such as income assistance, housing, and employment programs—can improve safety options and make it easier for individuals to leave abusive or unsafe relationships (Tubman et al., 2024).

D. ASSESSMENT AND INTERVENTION PRIORITIES

1. **Use comprehensive assessment frameworks.**

When GBV occurs alongside substance use and minority stress, providers should conduct broad, integrated assessments and tailor interventions to address the factors that initiate or intensify GBV.

This may include assessing safety, substance use patterns, trauma, mental health, and social determinants while exploring how these factors interact and shape risk and support needs.

2. **Acknowledge diversity and structural pressures.**

Supporting transgender survivors requires recognizing the diversity within this population, addressing shame, stigma, and minority stress, and understanding how power dynamics, gender identity, and structural inequities influence risk and responses to violence.

E. PROGRAM AND SYSTEM DESIGN

1. **Move beyond cis-heteronormative models.**
Programs built around cisgender, heterosexual assumptions often exclude or misrepresent transgender clients. Services should instead be grounded in the intersectional experiences of transgender people, particularly those living with multiple forms of marginalization (Kattari et al., 2022).

2. **Train teams on GBV tactics specific to transgender survivors.**
Providers must be able to identify forms of GBV that uniquely affect transgender individuals—such as controlling access to, or withholding, gender-affirming items (e.g., binders, makeup, or hormones). All resource lists and referral networks must be trans-inclusive (Kattari et al., 2022).

3. **Maintain affirming referral networks.**
Clinicians should be familiar with national and local 2SLGBTQIA+-led anti-violence organizations to ensure clients receive affirming, knowledgeable support.

F. CLIENT-CENTRED COMMUNICATION

1. **Create a safe and affirming starting point.**
Begin sessions with open-ended questions that allow clients to identify their concerns and priorities.

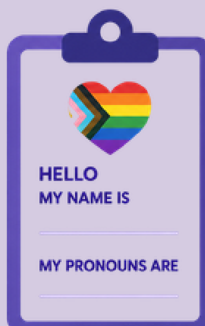
Always ask and use a client's chosen name and pronouns.

Questions like:

"What name would you like me to use?"

"What pronouns do you use?"

help build trust and affirm identity *(Ades, 2020).*



2. **Support healthy meaning-making around trauma.**
Service providers may encounter LGBTQIA+ survivors who have internalized stigma-based societal messages suggesting that their sexual orientation or gender identity is a result of past victimization. Although this belief is not evidence-based, it can influence the meaning making process. It is important to explore this with care, validating the individual's process of questioning while gently offering accurate, affirming information that challenges stigma-based assumptions (Ades, 2020).

Affirm identity.
Challenge misconceptions.
Support healing.

QUICK ACTION CHECKLIST – GBV-INCLUSIVE PRACTICE

- Use open-ended questions; always ask for and respect clients' names and pronouns (Ades, 2020).
- Screen for GBV using affirming, non-judgmental language.
- Use integrated assessments when minority stress and substance use intersect (Tubman et al., 2024).
- Train staff on GBV tactics that specifically affect transgender survivors (Kattari et al., 2022).
- Keep an updated list of 2SLGBTQIA+-led anti-violence organizations and referral resources.
- Provide practical and financial supports to expand safety options (Tubman et al., 2024).
- Address microaggressions and provider-driven bias through ongoing supervision and training.

9.10 STAFF COMPETENCIES AND SUPPORT NEEDS:

Teams function best when strengths-focused practice, universal trauma precautions, reflective supervision, and clear safety procedures are integrated into everyday work. Workers also need time and space to debrief, along with policies that support well-being and staff retention. Documentation should capture patterns and context, not just symptoms, including coercion, protective actions, and caregiving strengths.

1) Core Aspects:

Use strengths-focused, non-pathologizing approaches.
Frontline workers must view substance use and trauma-related behaviours as understandable responses to violence rather than as signs of personal weakness. This reframing is central to strengths-based practice and highlights women's resilience, coping skills, and protective strategies in the context of GBV (Bailey et al., 2019).

Recognize substance use as a coping strategy.
Many staff recognized that clients may use substances to self-soothe or manage PTSD symptoms and the broader stresses associated with GBV (Bailey et al., 2019).

Use diagnostic labels carefully.
Language matters, and diagnostic terms that label survivors as "disordered" can sometimes overlook the fact that these reactions are normal responses to trauma rather than signs of personal pathology (Bailey et al., 2019).

2) Foundational Training and Ongoing Development

Trauma-informed, gender-responsive training is essential.
Staff require training that addresses gender, trauma, and substance use, and they must have access to reflective practice and supervision to address biases and blind spots (Rodríguez, 2019).
Training must be continuous.
Trauma-responsive skills cannot be learned through a single workshop; capacity-building must be ongoing and integrated into routine staff development (National Center on Domestic Violence, Trauma & Mental Health, 2022a).

3) Universal Trauma Precautions

Assume trauma exposure; embed safety into every interaction.
Providers should work from the understanding that any client may have experienced sexual, emotional, or physical violence. Interactions should prioritize sensitivity, predictability, and choice, with or without disclosure (Cleary & Hungerford, 2015).
Model healing-centred relationships.
This includes reliable communication, respect, emotional authenticity, and an understanding that trauma, especially sexual violence, creates vulnerabilities that must be acknowledged to build trust (Cleary & Hungerford, 2015).

4) WORKER IMPACT AND EMOTIONAL RESPONSE

Exposure to GBV-related work affects providers.

Supporting people who have survived violence can take an emotional toll on care workers. This strain can result from both the complex needs of clients and practitioners' own emotional responses (Hickey et al., 2024).

To reduce practitioner bias and support staff well-being, connect and debrief with coworkers before and after client-facing work.

REFLECTIVE QUESTIONS PRACTITIONERS CAN ASK THEMSELVES ?

1. What assumptions am I making right now about this client's safety, capacity, compliance level, or choices?

2. Am I prioritizing my idea of "change" over the client's sense of safety and readiness?

3. Am I feeling urgency, frustration, or rescue impulses, and where might that be coming from?

4. How might my own values, experiences, or cultural lens be shaping my interpretation?

5. Whose needs am I centering in this moment: mine or the client's?

6. Am I responding to the client's nervous system cues or to my own discomfort?

7. What would it look like to slow down, stay curious, and return choice to the client?

Personal histories may be triggered.
Supporting clients with similar backgrounds can activate practitioners' own lived experiences, sometimes resulting in overwhelm or emotional fatigue (Hickey et al., 2024).

Acknowledge reactions to sustain care.
Recognizing and naming these responses is crucial to maintaining compassionate, ethical and sustainable practice (Allen et al., 2024).

5) SUPERVISION, DEBRIEFING AND ORGANIZATIONAL RESPONSIBILITIES

Supportive structures reduce burnout.
Workers benefit from ongoing supervision, access to debriefing, and workplace systems that prioritize emotional safety and help staff manage the demands of GBV- and substance use-related work (Hickey et al., 2024).

Invest in retention and workforce stability.
Organizations can help prevent burnout by ensuring:

- fair wages
- adequate paid leave
- ongoing training
- clear professional growth pathways
- workload protections (Eurasian Harm Reduction Association, 2021)

Encourage wellness and safety planning.
Agencies should implement policies that support staff well-being and help practitioners develop their own safety and wellness plans (Eurasian Harm Reduction Association, 2021).

6) PRACTICAL SAFETY MEASURES

Plan for safety in field and office settings.
Staff should work in pairs during higher-risk situations whenever possible. Agencies must maintain clear emergency response procedures that outline steps for obtaining immediate support and identify who must be notified during crises (Eurasian Harm Reduction Association, 2021).

DOCUMENTATION BEST PRACTICES

Context matters. Link mental health symptoms or substance use to experiences of abuse and coercion rather than viewing them as isolated diagnoses.

Name coercion clearly. Document how abusive partners use mental health concerns or substance use to control, threaten, or undermine survivors.

Be mindful of presentation bias. Document attempts by abusive partners to shape narratives or present themselves as more credible than the survivor.

Track control over care. Document interference with medications, treatment, or access to healthcare services. Safety can influence symptoms. Include observations that symptoms may lessen with increased safety, stability, and support.

Document strengths, not just risks. Record protective actions, coping strategies, and caregiving capacity, including signs of attunement and secure attachment with children.