The Jean Tweed Centre

JTC

For Women & Their Families

Hope & Recovery Toolkit

Essential Practices to Support Women Experiencing Substance Use & Gender-Based Violence

The Jean Tweed Centre, 2026

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CHAPTER 1

Purpose & Scope

1.

About the Jean Tweed Centre and the Purpose of the Hope and Recovery Toolkit

The Jean Tweed Centre (JTC) is a leading community-based organization offering a comprehensive range of services for women experiencing substance use, mental health, and gambling concerns. Our mission is to provide excellent care that supports women and their families in achieving health and well-being. Since 1983, we've focused on each woman's unique experience within her broader physical, emotional, social, and cultural context. We are committed to delivering individualized, gender- and trauma-informed care.

Over the decades, we have witnessed the profound, reciprocal relationship between gender-based violence (GBV), trauma, and substance use in the lives of the women we serve. Substance use often emerges as a coping response to trauma, including GBV. In contrast, women who use substances face an increased risk of experiencing violence due to the specific vulnerabilities associated with substance use.

Despite this clear connection, GBV and substance use are often addressed separately, leaving many women without access to comprehensive, integrated care. Service providers across both the substance use and GBV sectors possess deep expertise in their respective fields but often lack timely and adequate resources to build capacity for addressing both issues concurrently in the lives of women.

Through funding support from the Government of Ontario and collaboration and consultation with service providers and women with lived experience of GBV and substance use, we have developed the "Hope & Recovery Toolkit: Essential Practices to Support Women Experiencing Substance Use & Gender-Based Violence," which is intended to provide an easy-to-access guide to essential practices for service providers to recognize the signs and impact of GBV and substance use to support the needs of women in ways that are trauma-informed and gender-responsive.

This toolkit helps service providers by addressing a key gap in service delivery: access to tools and information on essential practices that anyone who supports women experiencing GBV and substance use can implement across sectors. We hope that this toolkit will support service providers in offering more holistic care that is responsive and timely for women experiencing GBV and substance use.

Imagine This...

Imagine a woman arriving at your service: she's juggling parenting, unpredictable work shifts, and constant safety concerns. To cope, she sometimes turns to substances to manage overwhelming stress. Some days, she's ready to talk; on others, just showing up is a victory.

This toolkit is for those moments. It offers simple, trauma- and violence-informed steps to help you recognize, respond, and connect—wherever a woman is in her journey. The approach is relational and woman-centred, acknowledging the complex, interwoven realities of gender-based violence and substance use, and focused on building trust at every interaction.

CHAPTER 2

HOPE & RECOVERY TOOLKIT: What is it and who is it for?

2.

About the Hope & Recovery Toolkit

This toolkit is intended to be an easy-to-use initial guide to essential practices that service providers can apply universally across settings to recognize the signs and impacts of GBV and substance use among women in ways that are relational, woman-centred, and trust-building. It is intended to be a quick reference guide or starting point based on findings from the current evidence and a review of the literature to support a more integrated approach to supporting women experiencing GBV and substance use.

2.1.WHO IS THE HOPE & RECOVERY TOOLKIT FOR?

The toolkit is intended to provide service providers from a wide range of disciplines and across sectors with a one-stop initial point of reference for evidence-informed essential practices to support women experiencing substance use and gender-based violence.

2.2. HOW TO USE THIS TOOLKIT

The Hope and Recovery Toolkit is organized into separate, interrelated chapters for easy reference and guidance for care workers and teams to access as needed, as an initial point of reference.

Chapters are intentionally written in short paragraphs and prompts to facilitate an initial point of guidance.

Practice Pearls:
Throughout the toolkit, Practice Pearls highlight concrete examples and tips for implementing the suggested essential practices.

Essential Chapters to read if you are short on time include:
The following two chapters are foundational pillars referenced throughout the toolkit.

- **Chapter 3 (Common Language & Concepts)**
- **Chapter 5 (Relational, Woman-centred, Trust-Building Approach)**

2.3. HOW THE TOOLKIT IS ORGANIZED: CHAPTER BY CHAPTER OVERVIEW

CHAPTER 1 — PURPOSE & SCOPE

This opening chapter introduces the Jean Tweed Centre and the purpose of the Hope & Recovery Toolkit in a simple, practical way. It names the gap that many women experience- support for Gender-Based Violence (GBV) and substance use that is often split across systems- and offers a clear intention: a strength-based, relational guide that service providers can use to make care safer and more collaborative.

CHAPTER 2 – ABOUT THE HOPE AND RECOVERY TOOLKIT

This chapter provides an overview of the toolkit, including who it is for and guidance on how to use it. It outlines the content of each chapter, explains the development process based on a rapid review of the evidence, and highlights the toolkit's limitations.

CHAPTER 3 – COMMON LANGUAGE & CONCEPTS

This chapter introduces the key terms, concepts, and frameworks used throughout the toolkit. It explores the substance use continuum, the gender-based violence (GBV) spectrum, and the principles of trauma- and violence-informed, strengths-based practice, providing a shared foundation for understanding the relationship between GBV, substance use, safety, and healing.

CHAPTER 4 - BACKGROUND: PREVALENCE, IMPACTS, ACES, AND WHY TRAUMA AND VIOLENCE INFORMED CARE (TVIC) MATTERS

This chapter connects the dots between trauma and adverse childhood experiences (ACEs), GBV, and substance use, reminding us that many coping strategies make sense in the context of these interrelated experiences. It surfaces the structural barriers women face and explains why a trauma- and violence-informed, gender-responsive approach helps.

CHAPTER 5 - RELATIONAL, WOMAN-CENTERED, TRUST-BUILDING APPROACH

A relational, woman-centred, trust-building approach is treated as the first intervention and the essential practice when supporting women experiencing GBV and substance use. This is the most important chapter of the toolkit, which seeks to describe how we can put this essential practice into action in our day-to-day interactions and work with women experiencing GBV and substance use. This chapter introduces "four anchors" to guide the application of a relational, woman-centred, trust-building approach grounded in the EQUIP Trauma- and Violence-Informed Care (TVIC) principles (a widely used, evidence-based framework developed by EQUIP Health Care).

CHAPTER 6 - INDIGENOUS WOMEN & CHILDREN: PERSPECTIVES AND IMPACTS OF GENDER-BASED VIOLENCE (GBV) & SUBSTANCE USE

This chapter provides an introductory overview of considerations related to structural inequities and colonial histories that impact GBV and substance use experiences of Indigenous women and children. It points readers toward learning first by seeking the expertise of Indigenous leaders and resources before acting. The chapter highlights essential Indigenous-led resources and supports practitioners in providing culturally safer, more informed support.

CHAPTER 7 - UNDERSTANDING CONTEXT, COPING, AND IMPACT

Chapter 7 offers a gentle, practical way to notice how GBV and substance use may show up in daily life without blame or labels. Using a dual continuum lens (Jean Tweed Centre & Yoon, 2026) and recognizing the role substance use coercion can play in people's lives helps us understand the meaning behind behaviours, reflect on strengths, and co-create practical next steps that increase safety.

CHAPTER 8 - RAPID REVIEW OF EVIDENCE (METHODS & SYNTHESIS)

This summary explains how evidence and lived experience have shaped the toolkit's development.

CHAPTER 9 – RAPID REVIEW OF EVIDENCE KEY TERMS

This chapter summarizes the key learnings and themes from the review of the evidence and literature conducted to inform the development of this toolkit. It distills helpful themes from the literature about what supports access, what reduces barriers, and which practices can be applied across settings.

CHAPTER 10 — HOW TO ASK, SUPPORT, AND CONNECT WOMEN TO SERVICES: SCREENING, BRIEF INTERVENTION, REFERRAL TO TREATMENT (SBIRT)

This toolkit translates evidence from the literature through the SBIRT approach, guiding us on how to Ask, Support, and Connect women with the services they require. In this context, "screening" refers to inquiring about gender-based violence (GBV) and substance use in ways that are seamlessly integrated into everyday conversations, emphasizing relational, woman-centred, and trust-building methods. Therefore, the most effective approach to "screening" becomes a universal conversation in which "we ask everyone." Brief interventions utilize language aligned with Motivational Interviewing (MI), offer harm-reduction strategies, and incorporate safety planning. Referrals are designed as warm handoffs that respect individual pace and privacy, ensuring women have access to the necessary supports.

CHAPTER 11 — INTERSECTORAL & INTERSECTIONAL CONSIDERATIONS

This chapter widens the lens to the systems and structures that affect women experiencing GBV and substance use, spanning multiple sectors such as health, housing, justice, social services, and child welfare, and offers practical ways to coordinate.

Toolkit References

A consolidated reference list that supports the toolkit's concepts, tools, and practice guidance is found at the end of each chapter and in a consolidated format at the end of the toolkit.

Appendices — PRISMA Diagrams & Tools

The appendices house the PRISMA diagrams from the peer-reviewed and grey literature searches and open-access tools in one spot for quick use.

CHAPTER 3

Common Language & Essential Concepts Used in this Toolkit: GBV, Substance Use Continuum, Dual Lens Continuum

3.

COMMON LANGUAGE USED IN THIS TOOLKIT: GBV, WOMEN, SUBSTANCE USE CONTINUUM/SPECTRUM

For a shared understanding, it is important to define and describe how terms and concepts are understood throughout the Hope and Recovery toolkit.

To facilitate this, we use the following definitions of the terms and their associated meanings that frame this toolkit:

How is "Woman" Defined in our toolkit?

Throughout the toolkit, the term "woman" is used to include anyone who identifies as a woman, regardless of the sex assigned at birth. This definition recognizes gender as a social and personal identity rather than being strictly tied to biological characteristics.

Reference: World Health Organization. (2022). Gender and health. World Health Organization. Retrieved from https://www.who.int/health-topics/gender

WHAT IS THE DEFINITION OF SUBSTANCE USE THAT IS USED FOR THIS TOOLKIT?

According to the "substance use across the spectrum" framework—adopted and promoted by the Canadian Centre on Substance Use and Addiction (CCSA) in collaboration with Health Canada—substance use is defined in a public health context that spans multiple forms of use, from non-use to substance use disorder (Figure 1). It recognizes that people can move along a continuum of benefit and harm. The framework acknowledges that people may fluctuate between these levels over time, emphasizing that substance use is not inherently problematic; only certain patterns lead to harm or substance use disorder.

Figure 1: Substance use continuum
Adapted from the public-health substance-use spectrum, which frames use as a continuum from non-use to substance use disorder, with beneficial, lower-risk, and higher-risk patterns in between (Health Canada, 2022).

3.1. HOW TO USE THIS TOOLKIT

Conversations about substance use work best when they begin with respect for the person's knowledge of her own life. The substance use continuum invites us to move away from labels and assumptions and toward understanding how and why substances are being used at this moment in time.

Across the continuum, substance use often reflects care and coping, not failure. For some, use is social or beneficial, woven into relationships and routines. For others, it may be episodic or experimental, tied to specific times, places, or transitions. As stress and harm accumulate, particularly in the context of gender-based violence, use may become riskier or begin to carry consequences for health, safety, work, or relationships.

At some points, substance use can feel difficult to change or out of control, especially when it is intertwined with trauma, coercion, pain, or isolation.

The continuum helps us hold all experiences without collapsing them into a single story. Use may become riskier or begin to carry consequences for health, safety, work, or relationships for some individuals at different points in their lives.

What matters most in using this framework is how we respond. A relational approach begins with consent and curiosity: a brief explanation of why we ask about substance use, a check-in to ensure it feels okay to talk, and openness to hearing what the substance is doing for her.

We listen for strengths, how she has been managing sleep, fear, pain, or loneliness; how she protects children; how she limits risk when she can. Naming these efforts builds trust and reinforces strengths.

As patterns shift along the continuum, our role is not to push for a particular outcome, but to match our support to what feels safe, possible, and supportive right now, and to respond in a way that honours each person's pace and capacity. With social or episodic use, that may mean normalizing conversations and offering information only if it is helpful. With riskier or harmful use, it may mean slowing down to explore what the substance is helping with, where it is getting in the way, and whether a small safety-focused change feels possible.

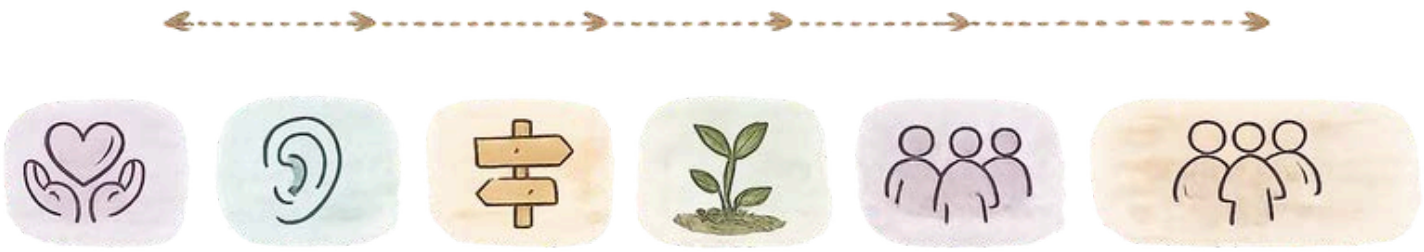
When use feels overwhelming, a trauma- and gender-informed response emphasizes dignity, hope, and partnership—opening pathways to care that are flexible, non-punitive, and responsive to readiness.

Throughout the continuum, context matters. Substance use does not occur in a vacuum. Gender-based violence, coercive control, poverty, racism, colonial harms, housing insecurity, and barriers to care can shape how and when substances are used.

In some relationships, substances themselves become tools of control—medications are withheld or diverted, use is pressured or punished, or treatment access is sabotaged. Recognizing substance use coercion allows us to respond with greater clarity and compassion, and to plan for safety, privacy, and choice rather than focusing narrowly on use reduction or stopping use.

What is substance use coercion?

Examples of substance use coercion women may experience include people in their lives who actively withhold substances and/or pressure women to use substances in the context of control and coercion. Other examples include exerting control over the woman's ability to participate in programs and services related to getting help for substance use.



Chapter 8 provides more details on how to ask about substance use, support people where they are, and connect them to services/support.

3.2. CONTINUUM OF SUBSTANCE USE TABLE: EXAMPLE OF STRENGTHS-BASED PRACTICE APPROACH FOR EACH STAGE OF THE CONTINUUM

The substance use continuum table below pairs each stage with a relational provider focus and language to try. These are not scripts, but reminders to speak in ways that keep the relationship at the centre: asking permission, reflecting meaning, offering options, and supporting micro steps that fit the realities of her life. Consider how cultural, linguistic, or personal backgrounds influence these strategies to ensure they are accessible and respectful for all clients. A safety plan, a grounding practice, a peer connection, or a warm introduction to another service can all be meaningful steps, especially when they are chosen by her and revisited over time.

Ultimately, the substance use continuum is a tool for walking alongside, not directing from ahead. People's needs change, risks rise and fall, and readiness shifts. When we hold the continuum lightly alongside the GBV spectrum, we create space for honesty, reduce stigma, and make it more likely that support will be accepted when it is needed. In a steady, trustworthy relationship, even small conversations can open doors and build confidence in the support process.

This table provides some examples of how to support relational, trust-building conversations about substance use across the continuum. It recognizes that people move across a continuum over time, and that substance use often reflects coping, context, and strengths—not deficits. This perspective encourages practitioners to see beyond problems and appreciate their clients' resilience.

TABLE 1: CONTINUUM OF SUBSTANCE USE TABLE: EXAMPLE OF STRENGTHS-BASED PRACTICE APPROACH FOR EACH STAGE OF THE CONTINUUM

Continuum stage	How this may show up in everyday life	Relational, strengths-based provider focus	Substance-specific considerations
 **Beneficial / social use**	Occasional or social use fits within daily routines (e.g., a drink with friends) and does not interfere with health, safety, or responsibilities.	Normalize conversation and curiosity. Use universal, non-judgmental questions and offer information only if helpful or requested, reinforcing trust and autonomy.	Alcohol and tobacco are widely socially accepted; be mindful of interactions with medications and changing needs over time.
 **Episodic or experimental use**	Infrequent or situational use (e.g., cannabis on weekends or during social gatherings).	Focus on safety and informed choice. Ask permission to discuss topics such as mixing substances, driving, or taking substances in unfamiliar, potentially unsafe settings.	Cannabis may affect sleep, anxiety, memory, or concentration; legal and social contexts can shape use.
 **Risky use**	Patterns that increase the chance of harm (e.g., binge drinking after conflict, taking more medication than prescribed).	Explore what the substance is helping with and where it may be creating challenges. Use brief, collaborative conversations (MI) to support safer-use planning and small, self-directed changes.	Alcohol and sedatives can interact with antidepressants or anxiolytics; benzodiazepines may be tightly controlled by partners or others.
 **Harmful use**	Use is beginning to affect health, relationships, work, housing, ability to function, and may be linked to safety concerns.	Validate strengths and efforts to cope. Offer harm-reduction options, discuss safety planning (including overdose prevention), and provide warm, choice-based referrals.	Some substances have increasing harms and risks, such as opioids, benzodiazepines, alcohol, and tobacco, which carry greater health risks with sustained, escalating use.
 **Substance use disorder**	Persistent patterns of use that feel difficult to change, and continued use despite significant impacts and multiple attempts to stop or reduce use due to significant physical and psychological dependence on a substance.	Emphasize dignity, hope, and partnership. Support access to integrated, gender- and trauma-informed care, peer support, and flexible pathways that respect readiness and choice.	Withdrawal safety (risk of seizures or other medical risks when stopping use), medication access, and coercion related to GBV and substances may require coordinated, trauma-informed planning.

Practice Pearl:
Not all Substances are the same

Not all substances are the same—each carries different benefits and risks. Talking together about commonly used substances like tobacco, alcohol, prescription opioids, and cannabis helps us focus on safety, health, and what matters most to the person. We start with curiosity, looking together at how substance use may affect health, safety, and daily life.

The following links to practice guidance sheets are designed for service providers to use during their conversations with women about the effects of substance use on women's health and in the perinatal period (updated 2024).

1. Women and Alcohol – English or French
2. Women and Cannabis
3. Women and Prescription Opioids
4. Women, Nicotine, and Tobacco

Potential ways to open conversations about substance use in ways that honour choice and align with relational approaches:

We ask everyone about any concerns they have about their use of alcohol, tobacco, and other substances. What worries you about your current use, if anything?

Some women are reluctant to talk about their substance use because they're worried about information being recorded or shared with other professionals. Sharing the agency's confidentiality policy should be standard practice.

Is there anything we need to know about your use of drugs or medications to support your health while you access support from us?

3.3. SPECTRUM OF GENDER-BASED VIOLENCE (GBV) — A RELATIONAL INTRODUCTION TO THE GBV SPECTRUM

When we sit with someone who is navigating harm, our first responsibility is to offer a steady, respectful relationship—one that makes room for what is hard and what is holding her together.

The GBV Spectrum table below (Table 2) is meant to support that kind of conversation. Rather than treating violence as a single incident or a label, the spectrum helps us notice how harm can show up across everyday life, from structural forces that narrow choices to boundary-pushing and coercive control, through psychological and emotional violence, and sometimes to physical or sexual assaults and life-threatening risk.

It reminds us that these are not neat boxes to sort a person into. People may experience several forms of violence at once, move across different points on the spectrum over time, and make wise, strategic choices to stay as safe as possible in the circumstances they face.

What makes this GBV spectrum a useful approach is the meaning we listen for within it. When a survivor describes "less visible," "covert" behaviours—monitoring, putdowns, pressure disguised as care—we hear early boundary erosion that can limit autonomy.

When money, medication, or documents are controlled, we name that coercive control, not conflict.

When someone describes gaslighting, humiliation, or threats, we recognize psychological harms that can be as impactful as physical injuries and often precede escalation.

And if there are signs of assault, strangulation, or reproductive control, we respond with first-line support, clear options, and careful safety planning, knowing that risk can escalate around separation and transitions.

We keep the bigger picture in mind. Colonial harms, racism, poverty, housing and immigration stress, and systemic discrimination can sit in the room with us even when they are not spoken aloud.

Seeing those forces clearly helps us avoid blaming the person for the conditions she is surviving. It also points us toward practical help and advocacy—warm introductions, safer documentation practices, and supports that reduce retelling and increase predictability.

The following practice example table pairs each part of the GBV spectrum with a relational focus and language to try. The focus is deliberately simple: begin with consent and curiosity; reflect on what you hear about safety, dignity, and connection; notice resistance and protective actions; and offer choices at a pace that fits.

The sample phrases are not scripts to follow word-for-word, but invitations to speak in ways that honour autonomy:

"Is there something that feels most important to talk through right now?"

"A lot of people find themselves navigating mixed feelings in situations like this. What has it been like for you?"

"Would it be okay to explore a few options together, and you can decide what fits for you?"

Because substance use and GBV can be intertwined, the spectrum also helps us bridge to the substance use continuum.

If we hear about medication being withheld, pressured use, or sabotage of care, we can name substance use coercion without judgment and plan for safer use, storage, or supervised dosing if that's what the person wants.

If use has been a way to manage pain, fear, or sleeplessness after violence, we can hold that with compassion and co-create micro steps that support safety and steadiness now—not just long-term change later.

Above all, the GBV Spectrum table is a reminder that trust is the intervention. Our role is not to sort or fix, but to walk alongside, keep doors open, and make the next step easier to take. In a steady relationship, one that sees both the inner logic of coping and the many faces of violence, small choices add up. The spectrum helps us notice where we are standing together today and what would support safety, choice, and connection right now.

Note

Movement across the GBV spectrum is not linear; multiple forms can occur simultaneously. The aim is not categorization, but context, safety, and trust (Wathen & Varcoe, 2019).

Attribution: This GBV table was informed by TVIC practice (EQUIP/CEWH), WHO LIVES first-line support, NCDVTMH guidance on supporting survivors who use substances (including substance-use coercion), and MMIWG Calls for Justice on structural/colonial harms.

3.4. SPECTRUM OF GENDER-BASED VIOLENCE (GBV) — PRACTICE EXAMPLE TABLE 2

Spectrum of GBV	How this may show up	Relational meaning & context	Strengths-based provider focus (EQUIP / TVIC)	Language to try (MI-aligned)
 **Structural & social harms**	Colonial harms, racism, economic exclusion, housing insecurity, immigration stress, systemic surveillance.	Violence is embedded in systems; survivors adapt creatively within constrained choices.	Acknowledge context; avoid individual blame; support access, advocacy, and practical resources (EQUIP; MMIWG, 2019).	"A lot of this comes from systems not built to support you. What's been hardest to navigate lately?"
 **Micro aggression & boundary violations**	Put-downs, monitoring, jealousy framed as care, isolation from friends.	Early erosion of boundaries increases dependence over time.	Name patterns gently; support boundary-setting; affirm judgement and insight. (CEWH)	"These kinds of behaviours can build over time. How do they affect your sense of safety, autonomy, or how you communicate?"
 **Coercive control**	Control of money, transport, documents, meds; threats around children, immigration, or substance use.	Control—not conflict—is the core harm; choices are strategic to reduce risk.	Prioritize safety and privacy; recognize resistance and protective actions; avoid escalation (Wathen & Varcoe, 2019; NCDVTMH).	"As you're describing this, I'm noticing some patterns that might be affecting your choices or independence. How does that feel to you?"
 **Psychological & Emotional violence**	Intimidation, gaslighting, humiliation, threats, manipulation, tech-facilitated abuse.	Psychological harms often precede escalation and can be as impactful as physical violence.	Validate impact; counter self-blame; support grounding and connection; document patterns (CEWH; TVIC).	"What you're describing sounds exhausting. How have you been getting through it?"
 **Physical & sexual violence**	Assault, strangulation, sexual coercion, reproductive control, injuries with explanations that don't fit.	Risk can escalate quickly; disclosure may feel unsafe; fear and ambivalence are common.	Follow LIVES first-line support; assess urgent safety; offer medical and legal options with consent (WHO LIVES).	"Your safety matters. Would it be okay to talk about what feels most urgent right now?"
 **Severe / life-threatening violence**	Repeated assaults, strangulation, weapon threats, stalking post-separation.	Leaving can increase danger; survival strategies may look contradictory from the outside.	Coordinate high-risk planning; involve specialized supports; maintain survivor choice (Wathen & Varcoe, 2019).	"You've been doing what you need to survive. We can look at options together, at your pace."

Indigenous-led references:

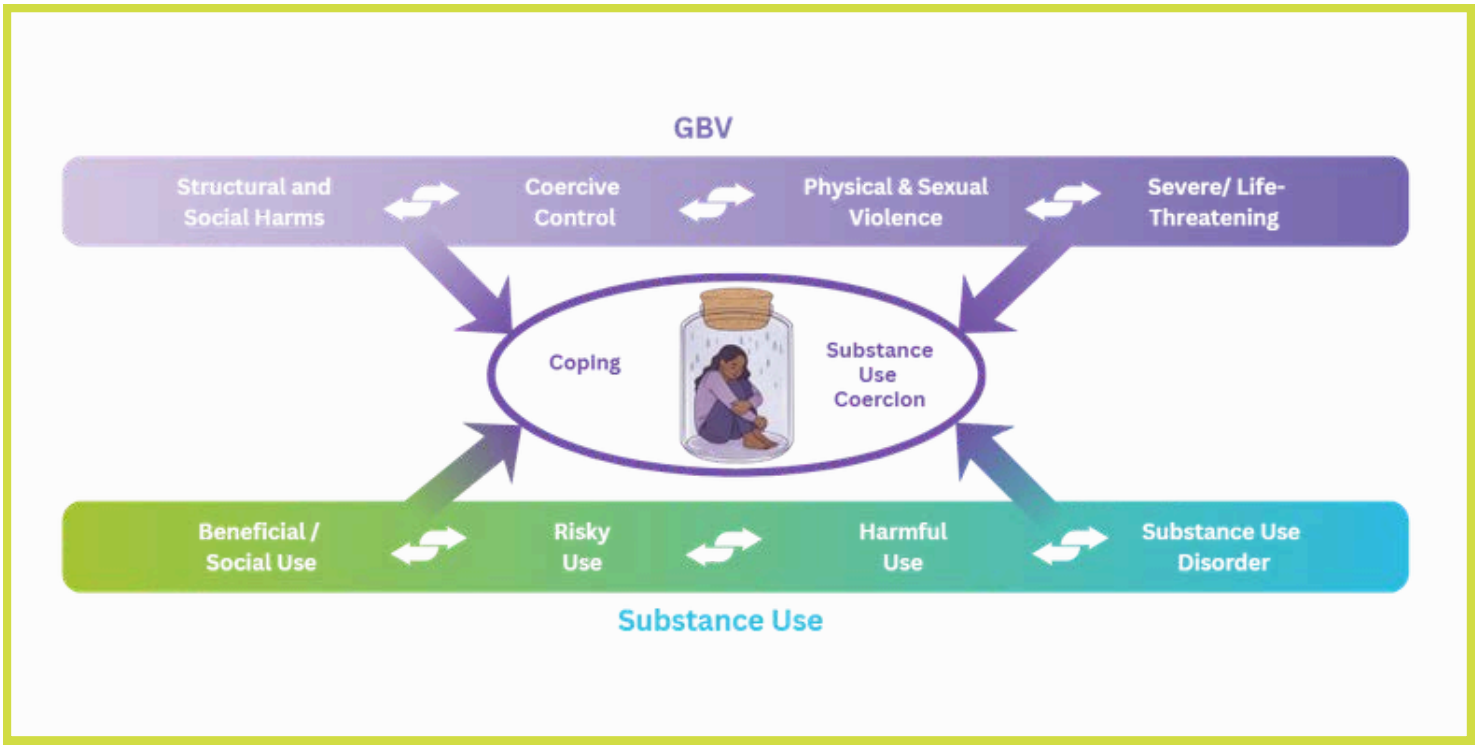
- National Inquiry into Missing and Murdered Indigenous Women and Girls (2019) — Calls for Justice (colonial violence, jurisdiction, accountability).
- First Nations Health Authority — Indigenous harm reduction (culture, ceremony, Elders, land-based healing as core care).
- Thunderbird Partnership Foundation (2023) — Land-based, culture-centred approaches in wellness.

3.5. Dual Continuum Lens to Support Women experiencing GBV and Substance Use:

The Dual Continuum Lens was created collaboratively by the Jean Tweed Centre and Rosanra Yoon (2026) as an original framework to support relational, trauma- and violence-informed practice within this toolkit.

It maps the GBV spectrum alongside the substance use continuum. It names the intersection as substance use coercion and coping, recognizing that partners or systems may pressure, punish, or sabotage use, and that substance use can also function as a trauma-linked coping strategy.

The dual continuum lens supports consent-led conversations, micro steps, and safety planning aligned with the TVIC-informed "Four Anchors" (Awareness; Safety & Trustworthiness; Choice/Collaboration/Connection; Strengths & Skill Building).



3.6. UNDERSTANDING HUMAN TRAFFICKING IN THE CONTEXT OF SUBSTANCE USE AND GBV

Human trafficking in the context of substance use and GBV is deeply interconnected, and a full analysis of the impact is beyond the capacity and expertise offered in this toolkit. We provide a broad overview to introduce the topic and encourage readers to learn more by accessing detailed resources and expertise. We offer some valuable resources as follows:

ESSENTIAL RESOURCES TO LEARN MORE ABOUT HUMAN TRAFFICKING

Ontario — Anti-Human Trafficking services & Indigenous-led supports
Province-wide directory of community and Indigenous-led services, plus education/training resources and the Canadian Human Trafficking Hotline (1-833-900-1010).
ontario.ca › Anti-human trafficking services and supports Human Trafficking services & Indigenous led supports wide directory of community and Indigenous led services, plus education/training 8339001010).

Toronto Police Service — Human Trafficking Enforcement Team (HTET)
Specialized police unit for sexual and labour trafficking investigations in Toronto; survivor-centred approach focusing on prevention, protection, prosecution, and partnerships; includes links to survivor resources and contact information.
tps.ca › Sex Crimes › Human Traffickingcentred approach focusing on

Aura Freedom International — Human trafficking info & training (Toronto based NGO)
Grassroots organization providing public education, training, and survivor support referrals; hosts an online Human Trafficking Info Hub and GBV resource centres for prevention and capacity building. aurafreedom.org

Public Safety Canada — Sex Trafficking (national campaign hub)
Federal page explaining what sex trafficking is, warning signs, survivor videos, and how to get help; links into Canada's National Strategy to Combat Human Trafficking.
canada.ca › Sex trafficking [canada.ca]

Ontario Native Women's Association (ONWA) — Indigenous led HT learning & supports
(e.g., Indigenous Anti-Human Trafficking Liaison/IAHTL, Aakwa'ode'ewin/Courage for Change) with culturally grounded, survivor-centred approaches for Indigenous women, girls, and Two--Spirit people.
onwa.ca › Learning & Resources — HT

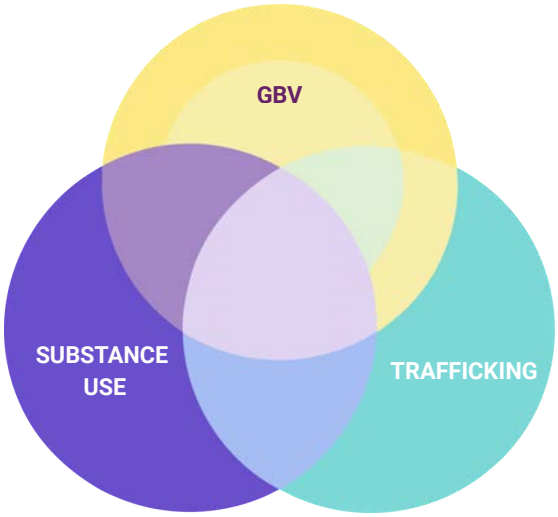
Covenant House Toronto — Traffick Stop: Sex Trafficking 101 (for youth, caregivers, providers)
Evidence-informed modules that explain luring/grooming tactics, red flags, barriers to leaving, plus classroom tools and pathways to specialized youth supports.
covenanthousetoronto.ca › Traffick Stop › Sex Trafficking 101

Joy Smith Foundation — National education & prevention programs
Canadian charity operating the National Human Trafficking Education Centre (NHTEC); offers free courses, workshops, and prevention materials; supports survivor-focused intervention initiatives across Canada.
joysmithfoundation.com-focused intervention initiatives across Canada.

Victim Services Toronto — Human Trafficking Prevention & Intervention
Provides crisis response, safety planning, emergency needs, and intensive case management; delivers youth/parent workshops and a survivor-authored Guiding Principles manual for trauma-informed practice.
victimservicestoronto.com › Human Trafficking Prevention & Intervention-authored -informed practice.

City of Toronto — End Trafficking TO (municipal overview & supports)
City actions, training across divisions, community supports, and data snapshots; includes shelter and housing pathways (e.g., beds at Covenant House).
toronto.ca › End Trafficking TO

THE INTERSECTION OF GENDER-BASED VIOLENCE, TRAFFICKING, AND SUBSTANCE USE



Human trafficking and sexual exploitation are deeply gendered, with women and girls disproportionately victimized (UNODC, 2022). Gender-based violence and inequities increase risk, with women and girls who are experiencing poverty, marginalization, racialization, and reduced socioeconomic status being at higher risk.

In Canada, most police-reported cases occur in urban centres and disproportionately involve women and girls under 25; the person using abusive tactics is often someone known to them, including intimate partners (Public Safety Canada, 2025; Statistics Canada, 2025).

Trafficking sits on the continuum of gender-based violence (GBV). The same dynamics we listen for in GBV—coercive control, threats, isolation, surveillance, and financial control—also operate in trafficking, often intensified by networks and profits that depend on maintaining control over someone's labour or body. Beyond a legal category, trafficking is an experience of ongoing violence embedded in social and economic inequities.

For many people, substance use is a coping strategy—a way to manage fear, pain, sleeplessness, or the aftermath of trauma. In trafficking and GBV contexts, substances can also be weaponized: introduced, pressured, withheld, or used as a threat to report, sabotage treatment, or justify punishment and surveillance. This pattern of substance-use coercion functions as an instrument of control that heightens risk and blocks access to services (ZapataAlma, 2022; ASPE, 2020).

CHAPTER 4

BACKGROUND
Prevalence and Impact of GBV & Substance Use Amongst Women

4.

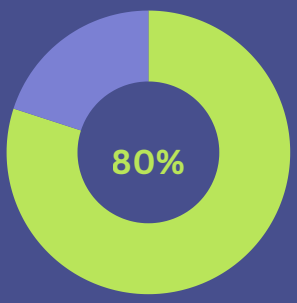
Background:

The evidence is clear: trauma, GBV, and substance use often occur together—but services seldom address both. The result is retelling, re-screening, and missed safety windows.

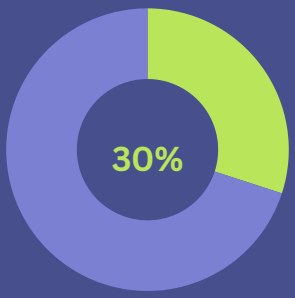
Service providers in the respective substance use and GBV sectors are well-versed in their respective areas, but often lack the training and support to provide an integrated response for women experiencing both substance use and GBV. For example, GBV service providers may not fully recognize the signs of substance use or know how to support women with substance use across the substance use continuum, including beneficial use, riskier use, and dependency. Similarly, substance use service providers may not be equipped to address the impact of GBV that underpins many women's substance use.

This disconnection leaves women underserved, as they often need integrated services that acknowledge the intersectionality of IPV, sexual violence, trauma, and substance use. Additionally, the lack of childcare, the stigma associated with substance use, and the unique health risks women face further exacerbate the challenges they encounter in seeking help.

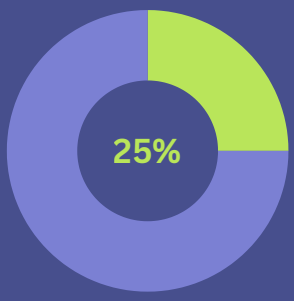
GBV STATS



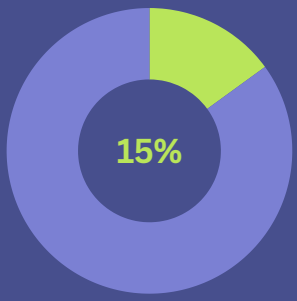
Over 80% of JTC clients report a history of trauma, including GBV, underscoring the critical need for integrated support.



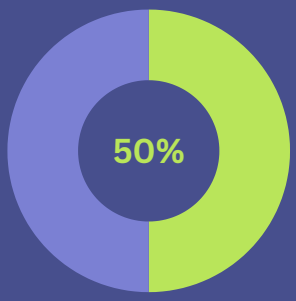
Approximately 30% of women in Canada have experienced intimate partner violence (IPV) in their lifetime (Government of Canada, 2022).



Around 25% of women have experienced sexual violence (Statistics Canada, 2021).



Substance use issues affect about 15% of women (Centre for Substance Use Disorder and Mental Health [CAMH], 2020).



Additionally, about 50% of those who have experienced IPV or sexual violence will require trauma-specific care (Canadian Women's Foundation, 2021).

4.1 REALIZING THE PREVALENCE AND IMPACT OF GBV & SUBSTANCE USE AMONGST WOMEN

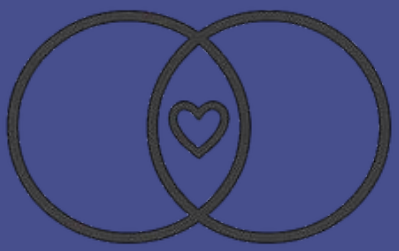
A. Substance Use & GBV:

- 65–85% of women with substance use issues report lifetime experiences of GBV (BC Society of Transition House, 2011).

- The relationship between GBV and substance use is bidirectional:
  Substances can lead to violent behaviours, while in other circumstances, substance use is a way of coping with victimization from violence (Benoit & Jauffret-Routside, 2015).

- Women who use substances and have experienced violence need support that addresses both the causes of substance use and the causes of violence or victimization, because violence can lead to substance use, make quitting harder, and increase the chance of returning to use (Benoit et al., 2015).

Because there is a significant correlation between victimization and substance use, all GBV service providers can address the issue of substance use, and substance use service providers can address GBV through routine screening, brief intervention, and referral to services as outlined in Chapter 8 of this toolkit.



4.2 THE LINK BETWEEN ADVERSE CHILDHOOD EXPERIENCES, SUBSTANCE USE, AND INTIMATE PARTNER VIOLENCE AMONG WOMEN

Adverse Childhood Experiences (ACEs)—including abuse, neglect, and household instability—are strongly associated with later risk of substance use disorders and gender-based violence (GBV) in adulthood.

Did you know?
Women who have lived through Adverse Childhood Experiences (ACEs) face higher risks of gender-based violence (GBV) across their lives and may use substances in ways that help them cope with fear, pain, or instability.

1) How ACEs Shape Substance Use
Trauma-linked coping:

- Women with higher ACE exposure are more likely to use substances to regulate distress and manage trauma-related symptoms—an understandable coping strategy that can become harmful over time (Morton et al., 2022; Felitti et al., 1998).

2) ACEs as a Predictor of GBV

- Meta-analyses of research studies show a positive association between ACEs and GBV (both victimization and perpetration) in adulthood (Zhu et al., 2024).
- Prospective studies find that cumulative ACE exposure increases the likelihood of experiencing physical GBV later in life, emphasizing the value of prevention and early intervention (Kaufman-Parks et al., 2025).

3) Overlapping Risks: ACEs, Substance Use, and GBV
Compounded vulnerabilities

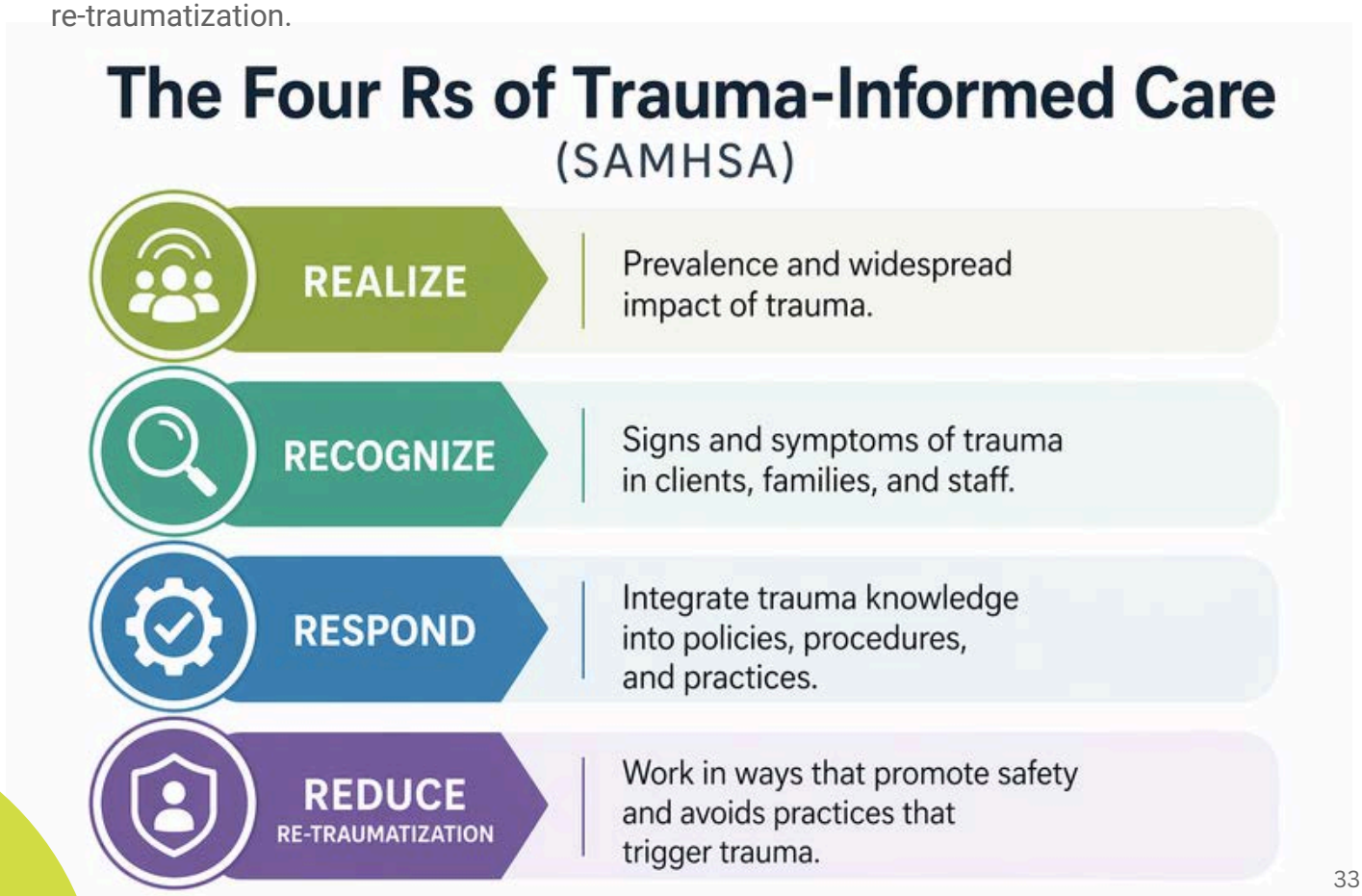
- For many women with ACE histories, substance use and GBV co-occur, creating layered health and safety risks and complicating engagement with services (El-Bassel et al., 2019; Brown & Masho, 2012).

Practice Takeaways

- **When ACE histories are present, routinely assess substance use and GBV together to identify co-occurring needs.**
- **Normalize coping: Frame substance use as a possible trauma-linked response that necessitates compassionate, evidence-based support.**
- **Stage-matched supports: Offer integrated services (e.g., Cognitive Behavioural Therapy (CBT), MI, safety planning, coordinated referral pathways) that address trauma impact alongside relationship and environmental safety.**
- **Prevention focus: Reduce long-term risk by addressing cumulative adversity early and strengthening protective factors (stable housing, peer support, economic supports, and culturally safe care).**

4.3 THE NEED FOR A TRAUMA-INFORMED, GENDER-RESPONSIVE APPROACH:

The intersection between substance use and gender-based violence for women is intricately linked, with a disproportionate number of women who seek help for substance use challenges also reporting lifetime experiences of violence and trauma (The Jean Tweed Centre [JTC], 2013). In the field of women's substance use, the connection between trauma and substance use is so prevalent that lifetime exposure to trauma is considered the norm and not the exception. To that end, services and programs that are trauma-informed realize the prevalence and impact of trauma amongst service recipients and staff who provide services recognize those impacts, and respond in ways that reduce re-traumatization.



4.4 TRAUMA-INFORMED PRINCIPLES:

A trauma-informed service system fosters principles of safety, trustworthiness, and transparency; collaboration and mutuality; empowerment; voice and choice; peer support; and attention to cultural, historical, and gender issues (Substance Use and Mental Health Services Administration [SAMHSA], 2021).

SAMHSA (Substance Use and Mental Health Services Administration) identifies six guiding principles for a trauma-informed approach. These principles are designed to help organizations create environments that promote healing and avoid re-traumatization:

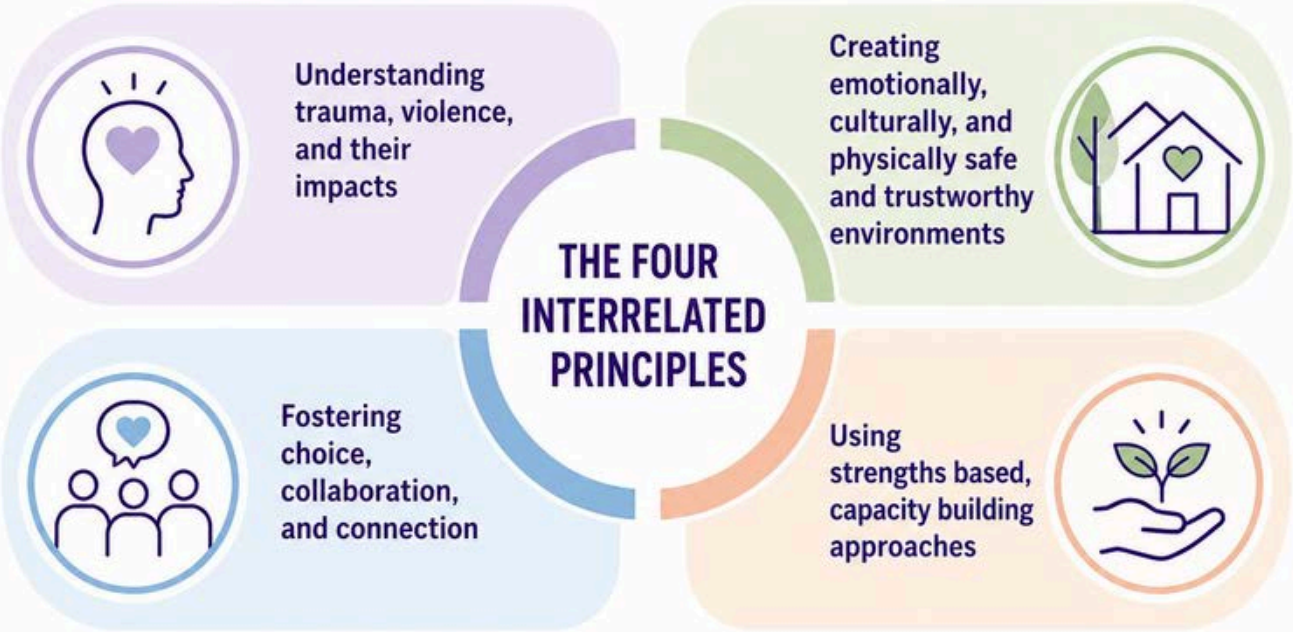
Source: JTC, 2013; SAMHSA, 2014

Practice Pearl: Defining Trauma from a Trauma-Informed Approach

- From a trauma-informed approach, trauma is defined by a wide range of experiences/situations that overwhelm a person's ability to cope and threaten their sense of safety and can affect both individuals and communities and generations (intergenerational). From this perspective, trauma is defined by its impact rather than specific events.
- Trauma-informed approaches to services and care prioritize safety (psychological, emotional, physical). They can be applied as a general approach that everyone can employ, versus trauma-specific treatments or therapies intended to treat symptoms of trauma or PTSD that trained specialists provide.

4.5 EQUIP HEALTH CARE'S TRAUMA- AND VIOLENCE-INFORMED CARE (TVIC) PRINCIPLES:

EQUIP's TVIC principles offer a practical way to make care safer and more responsive to the needs of people affected by trauma and ongoing violence.



These principles are paired with implementation tools that translate them into everyday actions at both the provider and organizational level (e.g., privacy checks, predictable processes, flexible options, and staff supports), which are summarized in resources developed by EQUIP Health Care and GTV Incubator: "Principles of Trauma- and Violence-Informed Care (TVIC)" (2024) and "TVIC: A Tool for Health and Social Service Organizations & Providers" (2021).

CHAPTER 5

Relational and Trust-Building Approach

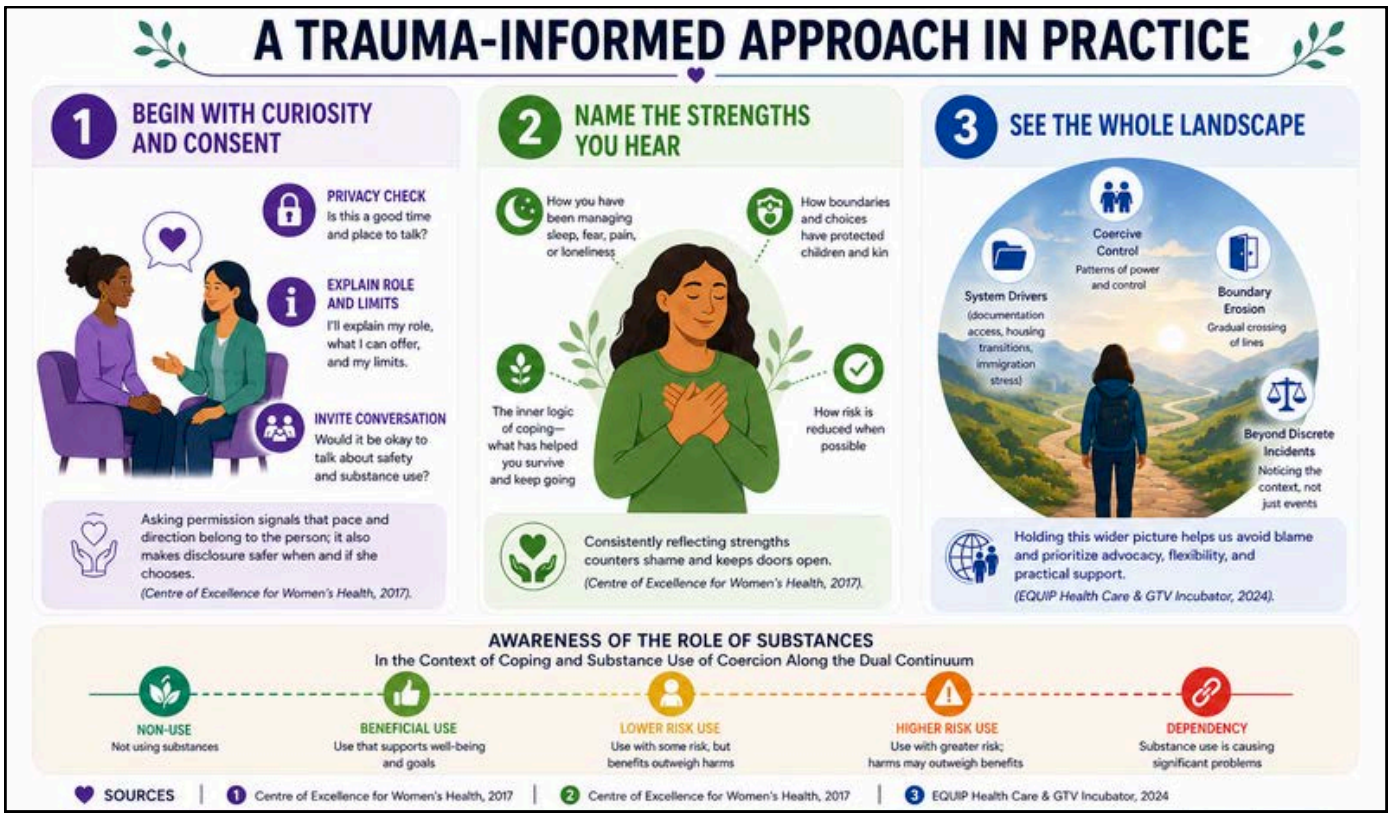
An Essential Practice to Support Women Experiencing GBV and Substance Use.

5.1.RELATIONAL, WOMAN-CENTRED, AND TRUST-BUILDING APPROACH IS AN ESSENTIAL PRACTICE

When we meet someone navigating substance use and gender-based violence (GBV), our first responsibility is to offer a steady, respectful relationship, one that notices strengths, honours self-determination, and moves at the person's pace. A relational and trust-building approach is not an add-on to clinical or counselling techniques; it is the condition that makes care safer, more equitable, and more useful in everyday life.

5.2.WHAT "RELATIONAL AND TRUST-BUILDING" LOOKS LIKE IN PRACTICE

The following infographic summarizes what a relational, trust-building, trauma-informed approach can look like in practice.



With riskier or harmful patterns, or when use feels overwhelming, slow down to explore meaning, co-create micro-steps, and connect to integrated, gender- and trauma-informed services that respect readiness and choice (Centre of Excellence for Women's Health, 2017; EQUIP Health Care & GTV Incubator, 2024).

Practice reflection

Use the Centre for Excellence in Women's Health's TIP reflective questions in quick huddles to ask, "What are we doing well to make this feel safe?" and "What else could we do?" (Centre for Excellence in Women's Health, 2017).

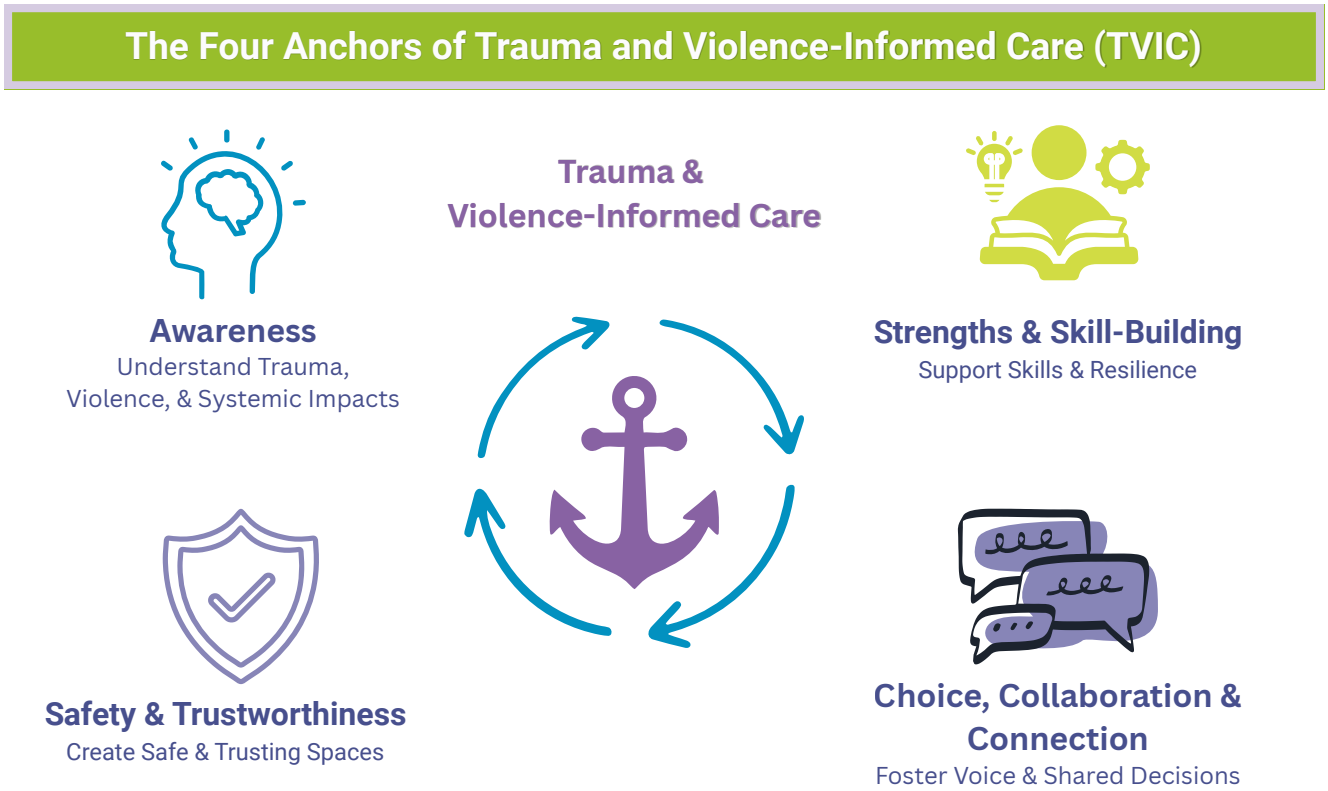
Hope. Help. Healing

5.3. THE "FOUR ANCHORS" FOR A RELATIONAL, WOMAN-CENTRED, TRUST-BUILDING APPROACH

The "four anchors" (Awareness, Safety & Trustworthiness, Choice/Collaboration/Connection, Strengths & Skill Building) for a relational and trust-building approach used throughout this toolkit is adapted from EQUIP Health Care's Trauma- and Violence-Informed Care (TVIC) principles.

1. **Awareness:** Be aware of the impacts of trauma/violence and attend to structural and systemic violence; design supports for staff well-being and practice safety around substance use.
2. **Safety & trustworthiness:** Create physical, emotional, cultural, and spiritual safety; make processes predictable; explain what to expect.
3. **Choice/collaboration/connection:** Invite participation, offer real options, and privilege the person's voice; build connections with peers and the community.
4. **Strengths & skill-building:** Notice resilience and protective actions; build skills for regulation and safety that fit today's priorities.

We apply these anchors in a relational, strengths-based, and trust-building manner tailored to support women experiencing gender-based violence and substance use.



Adapted by the Jean Tweed Centre and Yoon, R. (2026) from primary sources: EQUIP Health Care and GTV Incubator, "Principles of Trauma- and Violence-Informed Care (TVIC)" (2024) and "TVIC: A Tool for Health and Social Service Organizations & Providers" (2021).

5.4.WORKING AT THE INTERSECTIONS: SUBSTANCE USE, GBV, AND COERCION

Substance-use coercion—such as control of medications, pressure to use, or interference with care—sits at the intersection of GBV and substance use. Recognizing these patterns without judgment supports safety planning (e.g., medication privacy/storage, supervised dosing if desired) and warm transfers across services. Program guidance and low-barrier policy examples are available from NCDVTMH (National Center on Domestic Violence, Trauma & Mental Health, 2022a, 2022b).

PRACTICE TIP: SUBSTANCE-USE COERCION

Consider asking:

"Sometimes partners set rules about medications or their use. Has anything like that shown up for you?"

If YES, consider:

Planning for privacy around medications

Supporting access to safer-use supplies

Offering warm transfers that respect consent and do not require unnecessary disclosure

Source: National Center on Domestic Violence, Trauma & Mental Health (2022a, 2022b).

MOTIVATIONAL INTERVIEWING-ALIGNED CONVERSATIONS

- **"What's most important to talk about today?"**

(Centre of Excellence for Women's Health, 2017).

- **"What does [substance] help with most? Where is it getting in the way?"**

(Centre of Excellence for Women's Health, 2017).

- **"Sometimes partners set rules about medications or their use. Has anything like that shown up for you?"**

(National Center on Domestic Violence, Trauma & Mental Health, 2022b).

- **"Of the ideas we discussed, which—if any—fit this week?"**

(Centre of Excellence for Women's Health, 2017).

5.5. FIVE SIMPLE STEPS FOR TALKING ABOUT SAFETY AND USE (ABOUT 3–5 MINUTES)

The "Five Simple Steps for Talking About Safety and Use" is an original practice synthesis developed for this toolkit to translate TVIC principles into a brief, repeatable process. The CEWH trauma-informed practice and NCDVTMH guidance on safety, documentation, and substance-use coercion inform them.

The simple steps for talking about safety and use:

Prepare and invite — privacy check, role/limits, confidentiality, and a simple invitation: "We ask everyone about safety and health, including substance use. Would it be okay to talk about what matters most to you today?" (Centre of Excellence for Women's Health, 2017).

Map meaning — reflect what the substance is helping with and where it costs; listen for boundary violations or control; avoid labels; check language preferences (Centre of Excellence for Women's Health, 2017).

Co-create one micro-step — a safety adjustment, grounding practice, connection with a supportive peer, or a brief follow-up—chosen by her and doable this week (Centre of Excellence for Women's Health, 2017).

Plan for safety and documentation — notice and name patterns (e.g., coercion, medication interference) in a neutral, non-blaming way; confirm who can access notes; explore options for overdose prevention and safer ways to store and access medications (National Center on Domestic Violence, Trauma & Mental Health, 2022a).

Close with choice and predictability — offer options (including doing nothing for now), agree on next contact, and invite changes at any time (Centre of Excellence for Women's Health, 2017).

5.6. ORGANIZATIONAL ENABLERS (MAKING TRUST VISIBLE)

Policies and environment — Review guidance for unintended stigma; reframe around safety, consent, and harm reduction; use EQUIP TVIC tools to guide change (EQUIP Health Care and GTV Incubator, 2024; EQUIP Health Care and GTV Incubator, 2021).

Cross-sector pathways — Create warm-transfer scripts and co-located/integrated touchpoints across GBV, substance use, primary care, and housing (BC Society of Transition Houses, 2011/2022; Manitoba Association of Women's Shelters, n.d.).

Team reflection and quality — Use CEWH TIP reflective questions in brief huddles; build supervision that notices vicarious trauma and celebrates relational wins (Centre of Excellence for Women's Health, 2017).

5.7. DOCUMENTATION THAT PROTECTS

Document patterns, context, and protective actions; workers are encouraged to use discretion when documenting a person's words, use neutral language, and be clear about privacy. NCDVTMH provides examples of program-level policies that de-stigmatize disclosure and avoid punitive responses to use (National Center on Domestic Violence, Trauma and Mental Health, 2022a).

5.8. INDIGENOUS-LED, STRENGTHS-BASED STANCE

A strengths-based approach is central to many Indigenous knowledge systems: begin from what is strong, not what is wrong. In practice, this means recognizing resistance as wisdom, noticing protective actions, integrating cultural and land-based supports through community partnerships, and being accountable to Indigenous leadership in service design and data decisions (EQUIP Health Care and GTV Incubator, 2024; Centre of Excellence for Women's Health, 2017).

5.9. PROGRAM EVALUATION INDICATORS YOU CAN USE TO TRACK RELATIONAL AND TRUST-BUILDING APPROACH

Quality Indicators for Integrated SUD & IPV Care

Relational safety — % of encounters with privacy checks and consent for sensitive topics; feedback on feeling safe/understood.
(Centre of Excellence for Women's Health, 2017)

Choice & collaboration — % of notes with at least one client-chosen micro-step; documented options offered (including "wait and see").
(Centre of Excellence for Women's Health, 2017).

Low-barrier access — time from identification to warm transfer; presence of non-punitive, safety-framed policies; cross-sector case-conferencing logs.
(National Center on Domestic Violence, Trauma & Mental Health, 2022a).

Equity/TVIC practice — periodic use of EQUIP TVIC tools (environmental scan, staff prompts) with action items and follow-up.
(EQUIP Health Care & GTV Incubator, 2021).

CHAPTER 6

Indigenous Women & Children: Perspectives and Impacts of GBV & Substance Use

6.1. INDIGENOUS WOMEN & CHILDREN: PERSPECTIVES AND IMPACTS OF GENDER BASED VIOLENCE (GBV) & SUBSTANCE USE

The following chapter provides an initial overview of GBV and substance use as it relates to the experiences of Indigenous women and the impact on children in a very high-level way, which is limited in scope and expertise. We draw from key Indigenous documents and scholars, and we encourage readers to access and review the resources listed below for a much deeper understanding of the issues and solutions.

Essential Resources and Key Documents Related to Truth and Reconciliation and Indigenous Traditional Knowledge and Practices:

Truth and Reconciliation Commission of Canada (NCTR): Official history, 94 Calls to Action, and background on the TRC; links to records now stewarded by the National Centre for Truth and Reconciliation. https://nctr.ca/about/history-of-the-trc/truth-and-reconciliation-commission-of-canada/

Indigenous Watchdog: An Indigenous-led, continuously updated tracker that monitors progress and gaps across all 94 Calls to Action, with issue pages and primary source links to inform local action. indigenouswatchdog.org [indigenous...tchdog.org]

Assembly of First Nations (AFN): National advocacy organization advancing First Nations' rights, self-determination, and policy change; good starting point for positions, resolutions, and national initiatives. afn.ca

Native Women's Association of Canada (NWAC): National Indigenous organization advancing the rights and well-being of Indigenous women, girls, and gender-diverse people, with resources on GBV, MMIWG2S+, health, and culturally relevant gender-based analysis. nwac.ca

Ontario Federation of Indigenous Friendship Centres (OFIFC): Provincial body supporting Friendship Centres as urban Indigenous hubs for culture-based programs, youth leadership, research, and community advocacy. ofifc.org

Native Child and Family Services of Toronto (NCFST): Indigenous-led multiservice agency providing culture-based child and family well-being, early years, youth, and holistic services in Toronto. nativechild.org

Anishnawbe Health Toronto (AHT): Toronto's Indigenous governed community health centre integrating Traditional Healers and western care across 60 programs (primary care, mental health, diabetes, perinatal, traditional healing). aht.ca

Four Directions Teachings (Interactive): A visually rich, Elder-narrated site sharing foundational teachings from five First Nations (e.g., Mi'kmaq, Mohawk, Ojibwe, Cree, Blackfoot), with classroom resources. fourdirectionsteachings.com [fourdirect...chings.com]

Thunder Woman Healing Lodge Society (TWHLS) — Indigenous-led, trauma-informed housing and supports for First Nations, Inuit and Métis 2SLGBTQIA+ women exiting the justice system; healing lodge programming, safe housing, and cultural reconnection in the GTA. twhls.ca

Indigenous scholars and Indigenous-led inquiries show that GBV and substance use are intertwined outcomes of settler colonialism that disrupted governance, gender roles, lands, and kinship systems, creating persistent structural risks (Anderson, 2016; MMIWG, 2019).

The National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) documents how historical and ongoing colonialism, including residential schools, the Sixties Scoop, and jurisdictional gaps, has produced intergenerational trauma and structural conditions that elevate exposure to violence and limit avenues to redress and promote healing. These conditions are not only historical; they remain active drivers of risk today.

Indigenous women often face unequal access to timely, culturally safe justice and a pattern of responses that minimize or misclassify harms, deterring reporting and help-seeking. The MMIWG Final Report highlights longstanding barriers such as inadequate investigations, poor coordination across jurisdictions, and limited trauma- and violence-informed practices alongside Calls for Justice that require systemic reform and Indigenous-led solutions.

Practice Pearl: Defining Trauma from a Trauma-Informed Approach

- “Don’t guess, ask and learn.”
- When supporting Indigenous women and children experiencing GBV and substance use, pause and seek guidance from Indigenous Knowledge Keepers, Elders, and Indigenous-led services rather than assuming how to incorporate “traditional” practices.
- Invite local expertise and co-create next steps that honour Nation-specific teachings, language, ceremony, and consent.
- Your role is to make space, listen, and follow Indigenous leadership—not to interpret or improvise cultural practices.
- Colonial histories and ongoing systems shape risk and access for Indigenous women and Two-Spirit people. Indigenous-led approaches are evidence-informed and central to safety.

6.2. INTERGENERATIONAL TRAUMA

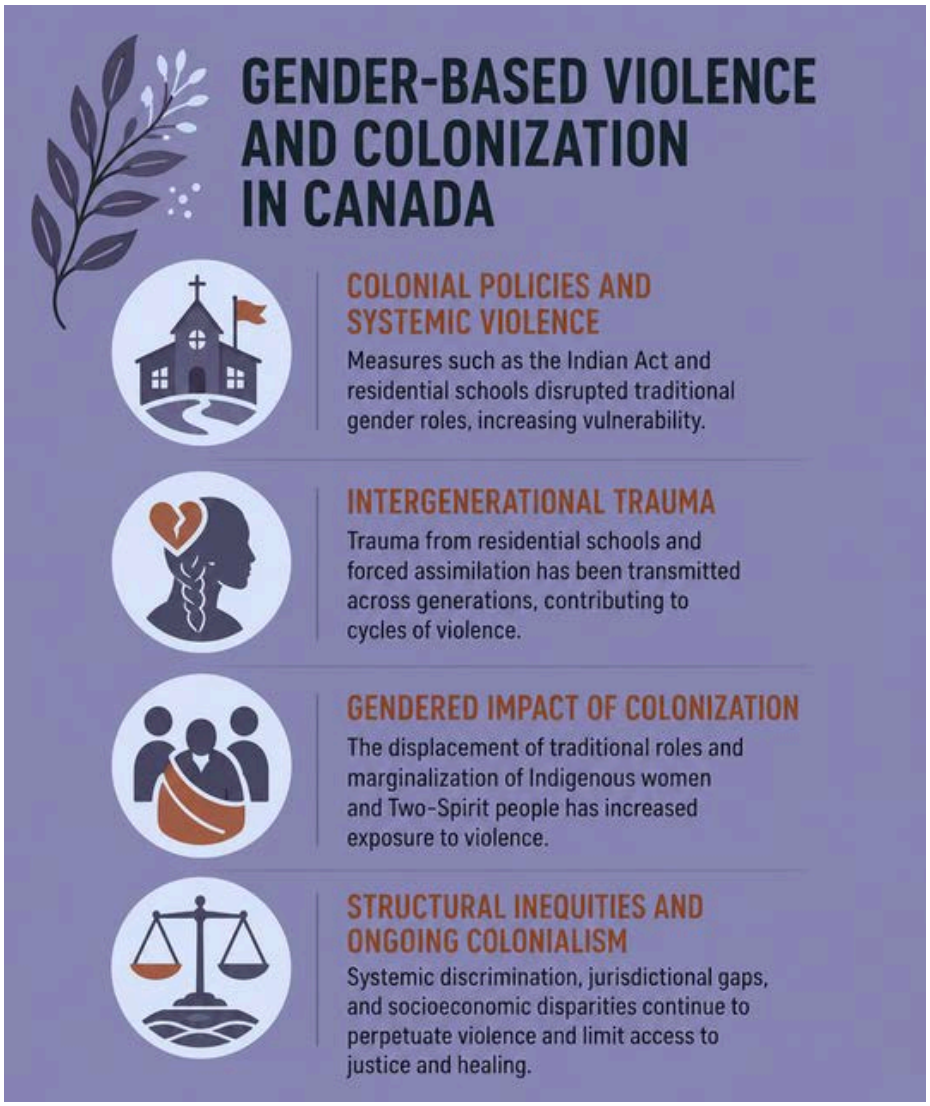
Trauma from residential schools and forced assimilation is transmitted across generations, manifesting as mental health challenges, substance use, and cycles of violence (Bombay et al., 2014).

Empirical work led by Anishinaabe scholar Amy Bombay links family residential school histories to higher contemporary stress exposure, poorer mental health, and increased susceptibility to substance use, with cumulative, multigenerational effects (Bombay, Matheson, & Anisman, 2014).

6.3. IMPACTS ON INDIGENOUS CHILDREN & FAMILIES

Trauma reverberates through parenting stress, family disruption, and child welfare involvement; integrated, women-only, culturally grounded programs (e.g., Sheway) show promise for mothers and infants (Bombay et al., 2014; CAMH KE Snapshot—Niccols et al.).

Indigenous scholars and leaders have documented how colonial policies continue to separate families and erode safety, with the MMIWG Final Report naming multigenerational and intergenerational trauma, insecure housing, and barriers to health and cultural supports as ongoing drivers of harm.



In child welfare specifically, Indigenous children are persistently overrepresented, a pattern tied less to “parental deficits” than to structural conditions and policy design—calling for Indigenous self-determination and culturally safe approaches.

6.4. WHAT WORKS (INDIGENOUS-LED)

Culture as foundation (ceremony, language, Elders, land) through Indigenous harm reduction and land-based healing; culturally relevant approaches to address colonial and gendered racism; whole-family, trauma- and violence-informed care to keep families safely together; and cross-sector implementation of MMIWG Calls for Justice are essential (FNHA, n.d.; Thunderbird Partnership Foundation, 2023; NWAC, 2020; MMIWG, 2019).

Of note is the recognition and acknowledgement of the differences between Western and Indigenous worldviews, especially when non-Indigenous care workers are developing treatment plans with Indigenous women.

Due to the impacts of colonization and structural inequities, there may be mistrust of formal institutions. Indigenous ways of knowing and healing have been discredited despite many being similar and aligned with Western science. As such, Indigenous ways of healing and intervention need to be at the centre of GBV and substance use interventions for Indigenous women. This approach includes interventions for men and boys to return to Indigenous ways of knowing that may contrast with Western approaches to intervention.

CHAPTER 7

Understanding Context, Coping, and Impact:

Gender-Based Violence and Substance Use

7.

Understanding Context, Coping, and Impact: Gender-Based Violence and Substance Use

7.1 WHY A RELATIONAL, STRENGTHS-BASED LENS?

Women's experiences of GBV and substance use are situated—shaped by relationships, safety, caregiving, community, and structural forces. A relational, trust-building approach begins with privacy, invitation, and pace-setting by the woman. It is not an add-on to clinical technique; it is the condition that makes care safer, more equitable, and more useful (EQUIP Health Care and GTV Incubator, 2024; Centre of Excellence for Women's Health, 2017).

When we meet someone navigating substance use and gender-based violence (GBV), we begin with a relationship. A strengths-based, relational approach treats trust as the first intervention. We offer privacy and predictability, ask permission before discussing sensitive topics, and move at the person's pace. We listen for what is hard and for what is holding her together—protective actions, caregiving, creativity, and resistance.

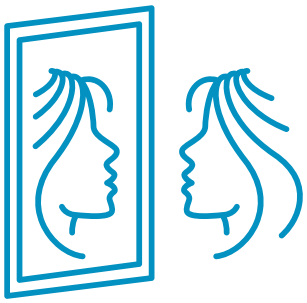
Throughout this chapter, we weave EQUIP's Trauma- and Violence-Informed Care (TVIC) principles into four anchors to guide and support relational, trust-building approaches:

WHAT THIS LOOKS LIKE IN PRACTICE:

Begin with curiosity and consent:

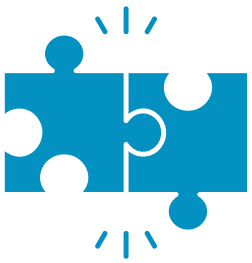
"We ask everyone about safety and health, including substance use. Would it be okay to talk about what matters most to you today?"

Explain your role and any limits, then invite the person to guide the focus



Reflect the strengths and protective actions you hear.

Match support to what is needed now, not to a predetermined pathway.



(Centre of Excellence for Women's Health, 2017).

7.2 HOW EXPERIENCES OF SUBSTANCE USE AND GBV MAY SHOW UP: POTENTIAL SIGNS TO GUIDE CARE WORKERS SUPPORTING WOMEN

WHAT TO KEEP IN MIND...

Experiences of GBV and substance use are diverse, contextual, and culturally situated.

Signs vary across individuals and circumstances. The goal is not to diagnose or label.

The goal is to notice patterns, invite consent led conversation, and offer practical support.

The lists below are examples (not a checklist) to help care workers listen for meaning, safety needs, and small next steps.

LISTEN FOR PATTERNS AND MEANINGS

- Coping that helps in one area but costs in another (e.g., substance use supports sleep yet strains housing or relationships).
- Boundary pushing or control framed as “care” (e.g., controlling medications, transport, phone).
- Transitions that increase risk (moves, pregnancy/post-partum, court dates, separation, new treatment).

HOW EXPERIENCES MAY SHOW UP IN EVERYDAY LIFE

Listen for patterns and meanings in daily life: contextual coping; boundary-pushing or control; psychological/emotional harms; and periods of increased risk during transitions.

(EQUIP Health Care & GTV Incubator, 2024)

PSYCHOLOGICAL & EMOTIONAL

How experiences may show up psychologically & emotionally:

- Heightened anxiety, hypervigilance, irritability, or feeling "on edge."
- Emotional numbing, flattened affect, or sudden mood shifts tied to safety cues.
- Guilt, shame, or self-blame after incidents or when coping involves substance use.
- Intrusions (nightmares, flashbacks) or difficulty staying present during stressful moments.
- Grief and loss (relationships, children, housing, community, identity).

(EQUIP Health Care & GTV Incubator, 2024)

SOCIAL AND RELATIONAL

HOW EXPERIENCES MAY SHOW UP SOCIALLY & RELATIONALLY:

- Isolation from family/friends; restricted contact or supervised calls.
- A partner/other monitors movements or communications; insists on speaking for her.
- Financial control (withholding money/ID), reproductive control (pregnancy pressure, birth control sabotage), or co-parenting threats.
- Needing to stay with a partner due to the risk of losing housing, income, transportation, or protection from others.
- Peer networks that feel safer than formal services, especially when stigma is high.

(EQUIP Health Care & GTV Incubator, 2024)

HOW EXPERIENCES MAY SHOW UP IN HEALTH/MEDICAL NEEDS:

- Sleep disturbance, chronic pain, headaches, stomach/digestive concerns, or diffuse somatic/physical symptoms.
- Medication interference (missing doses; someone controlling storage/administration).
- Interrupted care (missed appointments when privacy or transport is constrained).
- Pregnancy-related stressors (fear of child welfare involvement; limited prenatal continuity).
- Overdose risk or drug toxicity concerns (especially after periods of reduced use).
- Intoxication-related health risks (alcohol induced falls, liver effects, pancreatitis).

(EQUIP Health Care & GTV Incubator, 2024)

Traumatic brain injuries (TBI) resulting from being hit in the head, strangulation, or other injuries can lead to repeated TBIs that are often under-recognized and misdiagnosed. The impacts of TBI can affect memory, mood regulation, cognition, behaviour, and engagement with services. Sessions may need to be modified. Referrals and connections to services that support TBI assessment and intervention through primary care providers and specialists may be needed to help clients access the TBI resources and services they require.

HOW EXPERIENCES MAY SHOW UP BEHAVIOURALLY:

- Changes in substance use – use patterns (frequency, type, route), spikes after violence, or pressured/coerced use.
- Avoidance of certain questions, places, or people that cue danger.
- Missed or last-minute rescheduled visits when surveillance is high or transport is controlled.
- Risk-taking or sudden withdrawal from usual activities following a destabilizing event.

HOW EXPERIENCES MAY SHOW UP IN THE BODY/PHYSICALLY:

- Head/neck injuries, bruises, or patterned injuries with explanations that don't fit.
- Signs consistent with strangulation (voice changes, swallowing pain, headaches, dizziness).
- Reproductive injuries or frequent UTIs/STIs; contraceptive failures tied to control.
- Neglected dental or wound care when access is unsafe or restricted.

NOT EVERY SIGN/IMPACT IS VISIBLE

When GBV and substance use intersect, warning signs may appear as inconsistent stories, missed appointments, or remaining with a partner because housing or transportation is tied to that relationship. Treat these as context, not "non-compliance."

Practice Pearl: Barriers to Recognition

Many women normalize trauma responses or avoid disclosure because of stigma, fear of judgment, immigration or legal concerns, or distrust of systems. A predictable process, clear roles and limits, and choice at every step help build safety, allowing women to share only what is needed today.

Some ways to ask about GBV and substance use:

- "We ask everyone about safety and health, including substance use.
- "Would it be okay to talk about what feels most important to you today?"
- "I'm not here to put labels on your substance use or your relationship. I'm here to notice patterns with you and explore how they've been impacting you."
- "Sometimes partners pressure or control substance use or medications. Has anything like that been happening for you?"
- "Many people use substances to cope with stress or past experiences. Which of these options feels doable and supportive?"

Psychological & Emotional
Anxiety, hypervigilance, emotional numbing, guilt/shame, and intrusive memories.

Social & Relational
Isolation; control over phone, transportation, or medications; financial or reproductive control.

Health/ Medical
Sleep disturbances, chronic pain, gastrointestinal complaints, and interrupted care.

Physical
Head and neck injuries, visible signs of injury, reproductive injuries, and wounds or dental injuries.

Behavioural
Shifts in substance use patterns; coerced use; increased use after violence; avoidance.

Environmental & Systemic
Lack of safe access to a phone, transportation, or identification; housing precarity; court or legal stress; child welfare fears; and experiences of racism or colonial harms.

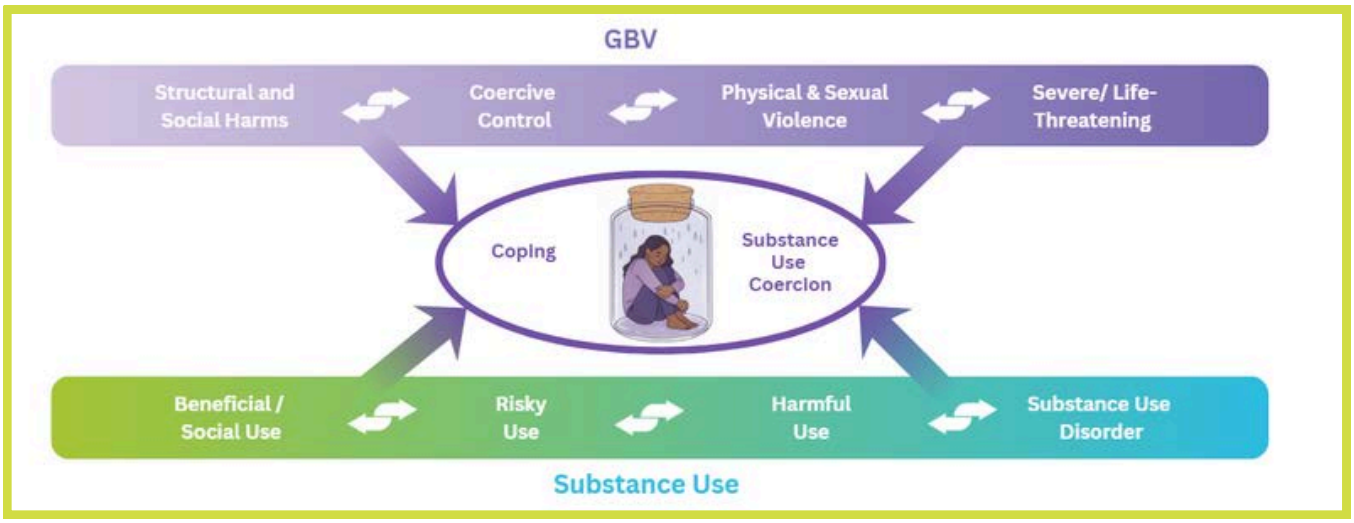
Documentation Nudge (for Staff)

Use neutral, non-stigmatizing language. Capture patterns (e.g., control over medications or transportation; pressured or coerced use; escalation around court dates), protective actions, and what matters most to her. Confirm who can access records and plan for safe communication. Document strengths and safety planning, as well as goals and strategies that support success.

7.3. USING THE DUAL-CONTINUUM LENS

Women may be at different points across the Substance-Use Continuum and the GBV Spectrum over time. Mapping both helps name what is happening without blame or labels and supports choosing a small, doable micro-step together.

Pause to notice what the substance is helping with, where it gets in the way, and what "safer" would look like this week.



How the Two Lenses Work Together (in Practice)

Rather than scoring or labelling, we gently map the woman's experience across both lenses (GBV and substance use). On the substance-use side, that might mean noticing whether use has been social, episodic, risky, harmful, or overwhelming and asking what each pattern has been helping with and hindering, including impacts on health and wellness. On the GBV side, we listen for boundary-pushing, coercive control, psychological harm, and any signs of physical or sexual violence, remembering that risks can rise during separation and transitions.

Substance-use coercion bridges the two lenses: partners may control or divert medications, pressure someone to use, sabotage care, or threaten consequences around treatment. Naming these patterns without judgment often brings relief—many people have never had this link acknowledged out loud.

SEEING OVERLAYS (EXAMPLES TO NOTICE)

- Episodic use + boundary violations → validate coping and explore situational safety (timing, setting, transportation).

- Risky use + coercive control → explore substance-use coercion; plan safer use, medication storage/privacy, and supervised dosing options if relevant.

- Harmful use + psychological abuse → provide first-line support (LIVES), harm-reduction strategies, warm transfers, and peer accompaniment

- Feeling stuck (SUD) + severe violence → support high-risk safety planning, integrated gender- and trauma-informed pathways, privacy protections, and careful documentation of patterns.

RELATIONAL LANGUAGE TO TRY (MI-ALIGNED)

- “What feels most important to talk about today?”
- “What does [substance] help with most? Where is it getting in the way?”
- “Sometimes partners set rules about medications or use. Has anything like that shown up for you?”
- “Of the ideas we discussed, which (if any) feel like they fit this week?”
- “You’ve been doing a lot to get through this. What would a little more safety or steadiness look like right now?”

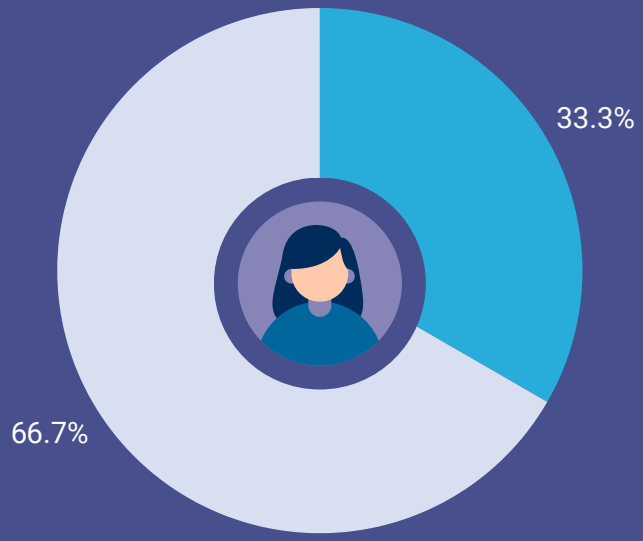
Why This Matters

Trust is the intervention. In a steady relationship—one that sees both the inner logic of substance use and the many faces of violence—small choices add up. People move across continuums; our role is to walk alongside, keep doors open, and make the next step easier to take.

DID YOU KNOW?

According to the World Health Organization (WHO), “1 in 3 women globally experience gender-based violence” (2021). Considering this widespread prevalence, routinely asking women about GBV during routine processes of care—from initial screening through regular, repeated screening during subsequent contacts—is necessary to enable timely support and access to services.

Asking About GBV Routinely From First Contact and Throughout Service Engagement



7.4. SUBSTANCE-USE COERCION (A BRIDGE BETWEEN LENSES)

Sometimes partners control medications, pressure someone to use substances, sabotage care, or leverage disclosure to punish. Naming substance-use coercion without judgment supports collaborative safety planning—such as medication privacy, safer-use options, and supervised dosing if desired—as well as consent-based warm transfers.

Practice Takeaway

Normalize, Don't Pathologize
Name substance use as a coping response and emphasize choice and safety.

Language to Try: **"Sometimes partners set rules about medications or substance use. Has anything like that shown up for you? If so, what would feel safer this week?"**

Practice Takeaway

Flag Possible TBI/Strangulation
Ask about head or neck pressure, loss of consciousness, memory gaps, and changes in voice or swallowing.

Adapt session length, provide written summaries, and consider referral.

Myth Buster: Misconceptions about “BPD”

MYTH: “People with Borderline Personality Disorder (BPD)” are attention-seeking, manipulative, or have multiple personalities.

FACT: Research shows that people with BPD experience emotions more intensely and for longer durations; behaviours often misinterpreted as attention-seeking are driven by distress, not intention (Navarre, 2025). What looks like “attention-seeking” is usually connection-seeking or the nervous system trying to feel safe after a perceived threat or abandonment (Navarre, 2025).

According to the DSM-5-TR, Borderline Personality Disorder (BPD) is a diagnosed condition characterized by a “pervasive pattern of instability in interpersonal relationships, self-image, and affects, along with marked impulsivity, beginning by early adulthood and present in a variety of contexts” (American Psychiatric Association [APA], 2022). The diagnosis requires that specific diagnostic criteria be met and must be made by a qualified health professional authorized to assess and diagnose the condition. Often, people diagnosed with borderline personality disorder have histories of multiple and complex traumas.

7.5. RESPONDING TO HOW THE IMPACTS OF GBV AND SUBSTANCE USE SHOW UP FOR WOMEN

Women experiencing gender-based violence (GBV) and substance use face compounded vulnerabilities, requiring integrated, trauma-informed, and gender-responsive approaches. Research and global guidelines emphasize the following best practices:

A.

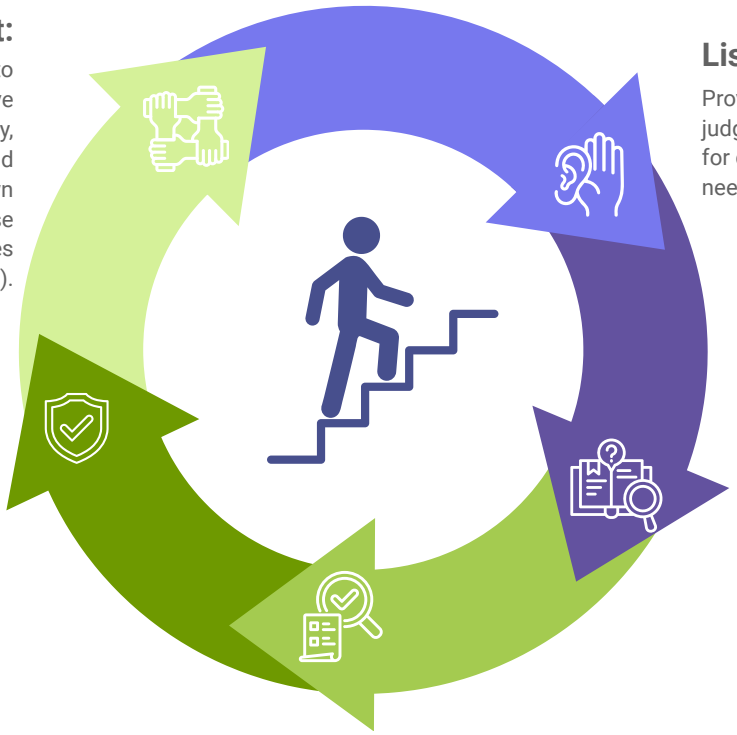
APPLY TRAUMA-INFORMED AND SURVIVOR-CENTRED CARE

Ensure safety, trust, and empowerment in all interactions. (SAMHSA, 2014)

Avoid re-traumatization by using non-judgmental, empathetic communication and respecting autonomy. (WHO, 2013)

B. PRACTICAL STEPS: LIVES

Support:
Provide warm referrals to integrated, gender-responsive services (e.g., Seeking Safety, Helping Women Recover, and TREM) that have been shown to improve both substance use and trauma outcomes (Johnstone et al., 2023).



Listen:
Provide an empathetic, non-judgmental space; avoid pressing for details beyond clinical safety needs (WHO, 2013).

Enhance safety:
Develop safety and harm-reduction plans (e.g., overdose prevention and safer-use strategies) and document threats such as strangulation (Moir et al., 2022; WHO, 2013).

Inquire:
Assess immediate safety, health, and substance-related risks; explore coercion, withdrawal risks, and child safety concerns (WHO, 2013; UNODC, 2023).

Validate:
Affirm that the violence is not the survivor's fault; acknowledge trauma and substance use as coping responses (WHO, 2013).

C. SCREENING, DOCUMENTATION, AND COLLABORATION:

- Screen for GBV and substance use **together** in confidential settings (WHO, 2013).
- Use validated tools and ensure culturally sensitive practices (Johnstone et al., 2023).
- Provide warm referrals—helping individuals connect with another service or program through service navigation and more hands-on support than providing information alone—to trauma-informed substance use disorder treatment programs such as Seeking Safety and Helping Women Recover (Najavits, 2015).
- Prioritize survivor choice and map local referral pathways (WHO, 2013).
- Coordinate with harm-reduction services, substance use services, legal and advocacy services, and child protection systems, recognizing the unique barriers faced by women who use drugs (UNODC, 2023; Romo-Avilés et al., 2024).

Details on screening are summarized in Chapter 10 of this toolkit.

D. INTEGRATED CASE MANAGEMENT AND COUNSELLING

- Often, women experiencing GBV and substance use require both case management support and counselling.
- Programs should offer integrated case management and counselling supports. When this is not possible, coordinated access to both services should be facilitated.

E. MULTISECTORAL COLLABORATION

- Coordinate with health, legal, housing, and social services to address complex needs.
- Build referral networks for mental health, substance use, and GBV advocacy services (Centers for Disease Control and Prevention [CDC], 2016).

F. ADDRESS STRUCTURAL BARRIERS

- Reduce stigma and discrimination in service delivery.
- Advocate for policies that integrate GBV and substance use services and supports, while also providing economic and housing support.
- Use trauma-informed, gender-responsive screening for both GBV and substance use.
- Provide integrated care models such as Seeking Safety or Helping Women Recover, which address trauma and substance use concurrently (Johnstone et al., 2023).

What is Harm Reduction?

Harm reduction is an evidence-supported, person-focused approach designed to lessen the health, social, and legal risks and harms linked to substance use without requiring people to stop using substances. In Canada, this approach emphasizes dignity, personal choice, and the active participation of people who use substances.

The focus is on supporting people who use substances where they are at, while promoting safety and minimizing substance-related harms in ways that align with the person's choices, wishes, and goals for their own recovery journey.

Practice Pearl:
A five-step relational conversation (about 3–5 minutes)

1) Prepare & Invite — Privacy check, role/limits, universal framing (“we ask everyone…”)

2) Map Meaning — What is the substance helping with? Where is it getting in the way? Notice boundary erosion or control.

3) Co-create One Micro-Step — A safety adjustment, grounding practice, peer contact, or shorter follow-up—chosen by her.

4) Plan for Safety & Documentation —Capture patterns (e.g., interference with medications) in neutral language; confirm who can access notes; consider safety risks and harm-reduction choices.

5) Close With Choice & Predictability — Offer options (including waiting), agree on next contact, and keep doors open.

CHAPTER 8

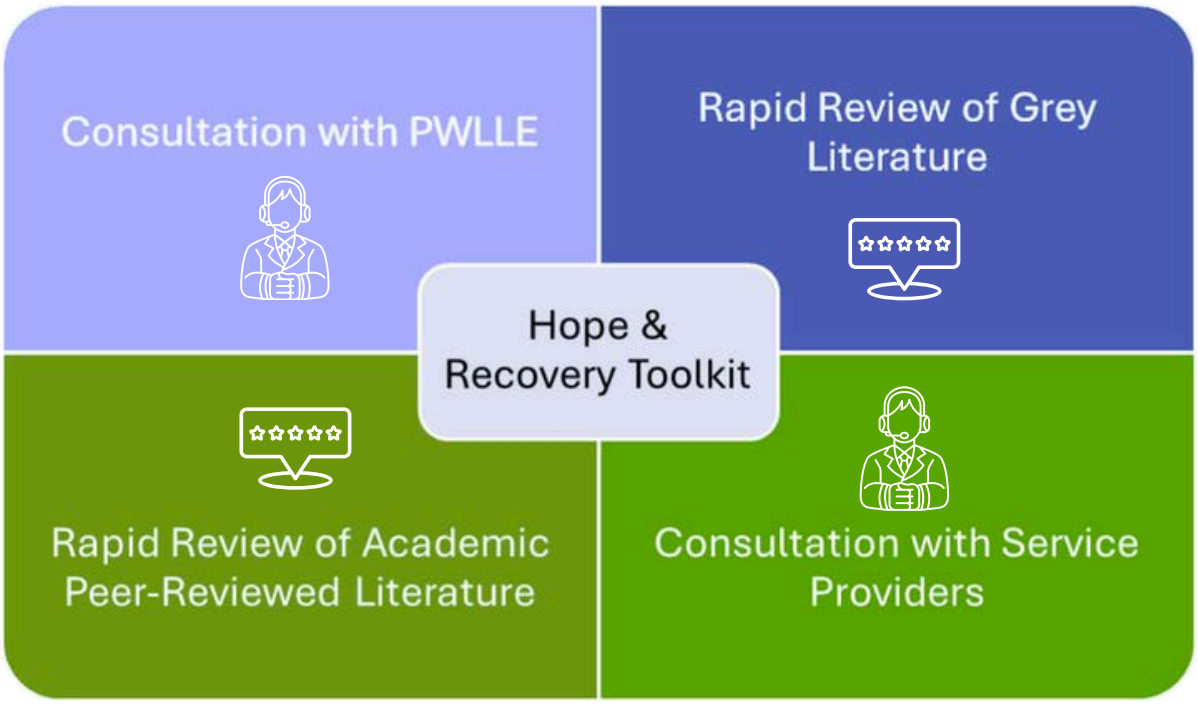
Rapid Evidence Synthesis: Methods Summary

8.

How Was the Hope & Recovery Toolkit Developed?

The Hope & Recovery Toolkit was developed through a multi-stage process that involved the following:

- Consultation with People with Living/Lived Experience (PWLLE) advisors regarding their insights and perspectives on the key competencies, skills, and knowledge important for care workers supporting women experiencing substance use and gender-based violence.
- A rapid review of the "grey literature."
- A rapid review of the academic literature.



8.1 LIMITATIONS OF THE TOOLKIT:

This toolkit reflects a point-in-time summary of current best practices and tools, and time constraints limited its scope.

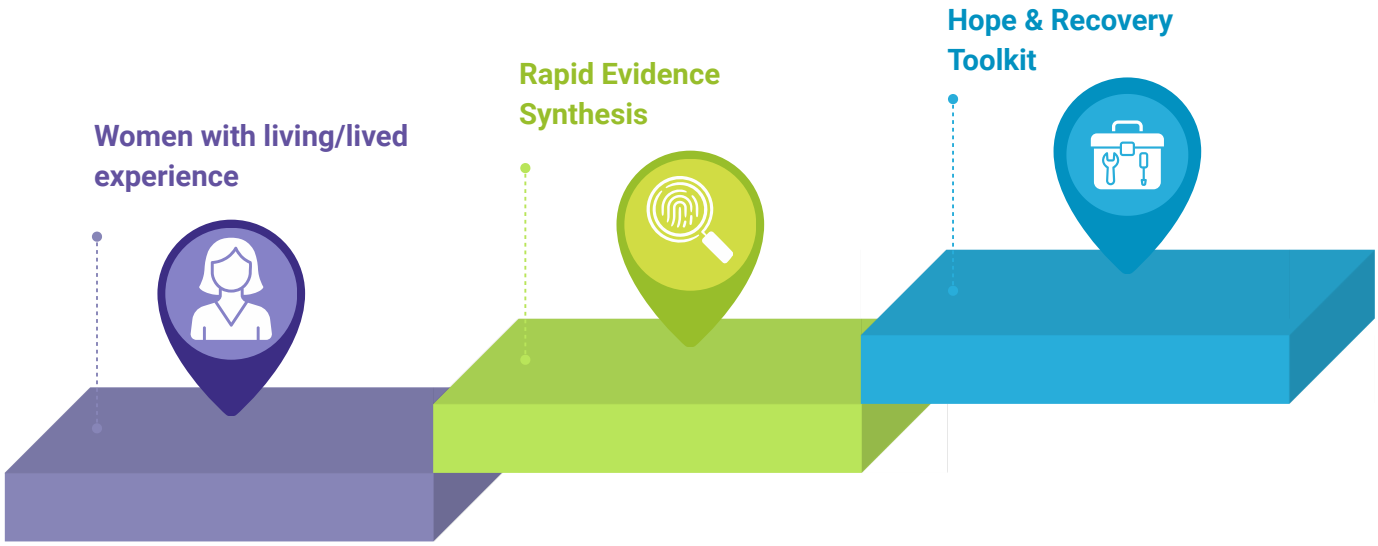
8.2 RAPID REVIEW OF EVIDENCE: METHODS SUMMARY

To synthesize current best practices and evidence on supporting women experiencing substance use and GBV for inclusion in the Hope & Recovery Toolkit, we employed an adapted rapid review methodology.

Rapid reviews differ from systematic literature reviews in both timescale and scope. They are often conducted in shorter timeframes and driven by practical needs, often in response to time-sensitive priorities. In this case, the goal was to rapidly synthesize a practical toolkit to support care service providers working with women experiencing substance use and GBV promptly.

Within a three-month timeframe, an adapted rapid review methodology was used to examine both the grey literature (materials openly available through common online sources) and the academic, peer-reviewed literature (published research available through academic databases).

Our process involved three key steps:



1

People with Lived Experience Advisory Consultation:

Focus groups were conducted with women with living/lived experience of GBV and substance use to explore which aspects of services were helpful, unhelpful, and what they felt was important to include in the Hope & Recovery Toolkit.

2 Rapid Evidence Synthesis:

- ***Grey Literature –*** *Publicly available through online sources.*
- ***Academic and Peer-****Reviewed Literature – Research literature accessible through academic databases.*

Concept:
Best practices, interventions, tools (e.g., screening, assessment, and referral), services, care approaches, and provider competencies (e.g., training, assessment, and skills) for supporting women and gender-diverse people experiencing substance use (SU) and gender-based violence (GBV).

Context:
- Community-based services.
- The toolkit is intended for community-based practitioners.
- Included settings: hospital-based and clinical settings.
- No restrictions were placed on service settings; findings were later stratified by setting where appropriate.

Identifying relevant studies.

Grey Literature
- Google Scholar/Google
- Hand-searching of references
- Guidelines
- Organizational documents
- Reports
- Date Range**:** 2015- 2025
- Language of Publication: English

Peer-Reviewed Literature
- Peer-reviewed journals
- Databases searched included PubMed, PsycINFO, Scopus, Web of Science, JSTOR, EBSCOhost, ProQuest, and Springer.
- Key Words: Population, Concept, Context (PCC): women and gender-diverse people, substance use (SU), gender-based violence (GBV), all settings, tools, and competencies.
- Limits Applied: English-language publications, published within the past 10 years, and focused on adults aged 18 years and older.
- Date Range: 2015- 2025
- Language of Publication: English

Study Selection

1) Title and Abstract Review (Two Reviewers)
Two team members independently reviewed the title and abstract of each result for relevance and inclusion using the Population, Concept, Context (PCC) inclusion criteria. Results that did not meet the inclusion criteria were excluded.

2) Full-Text Review and Final Selection of Findings
Team members reviewed all remaining articles and guidelines for relevance and final inclusion in the evidence synthesis. Only peer-reviewed articles and publications were included.

8.3 ADAPTED RAPID REVIEW METHODOLOGY:

To provide a structured process for the rapid review, we employed an adapted approach based on the scoping review methodology developed by Arksey & O'Malley to frame the search strategy and review steps outlined below:

Arksey and O'Malley Scoping Review Method — Adapted for Rapid Review

1 Identifying the Research Question

"What are best practices, tools, services, and provider competencies needed to support women and gender-diverse people experiencing substance use and GBV in community settings?"

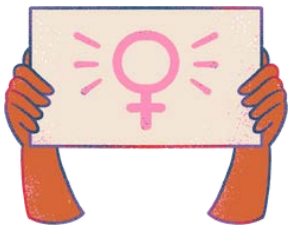
Population:

- Women and/or gender-diverse or gender-minority people experiencing substance use and GBV.
- **Excluded:** perpetrators of violence.

Definition of Substance Use: (Includes current recovery, ongoing recovery, and current substance use).

- Includes any substance across the spectrum of use, consistent with the Canadian Centre on Substance Use and Addiction (CCSA) continuum and inclusive of Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision criteria, ranging from mild to moderate substance use disorders.

Definition of Gender-Based Violence (GBV): (Past & Current)



- WAGE Definition of GBV: Violence based on gender norms and unequal power dynamics, perpetrated against someone based on their gender, gender expression, gender identity, or perceived gender. It takes many forms, including physical, economic, sexual, and emotional (psychological) abuse. (WAGE glossary)
- "Gender-based violence (GBV) is violence committed against someone based on their gender, gender expression, gender identity, or perceived gender. GBV can take many forms, including physical, sexual, societal, psychological, emotional, economic, and technology-facilitated violence."
- *WAGE: https://www.canada.ca/en/women-gender-equality/gender-based-violence/facts-stats.html*

- Adults aged 18 years and older.
- **Excluded:** literature focused on children and youth under 18 years of age.
- **Included:** pregnancy and parenting literature where the primary focus was on the pregnant or parenting person rather than the infant or child.

Exclusion Criteria:

Articles and publications were excluded if the setting was not community-based or if they addressed only substance use or GBV independently without examining the intersection of substance use (SU) and GBV together. Commentaries and non-peer-reviewed articles were also excluded.

The full PRISMA diagram can be found in Appendix A.

2 Charting the Data

A data extraction table based on key themes emerging from the articles was used to chart and organize findings from both the grey literature search and the peer-reviewed literature. The findings were organized using the SBIRT framework categories.

3 Collating, Summarizing, and Reporting the Results

The findings from the data extraction table were further analyzed according to the following categories:

- Interventions
- Tools
- Competencies
- Best Practices in service delivery, care, screening, assessment, brief intervention, referral, and treatment (SBIRT)

CHAPTER 9

Rapid Evidence Synthesis: Key Themes From The Literature Reviewed

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

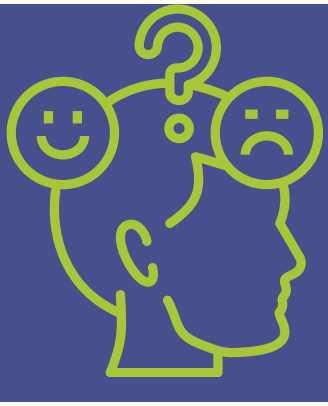
The following section summarizes the key themes that emerged from our rapid review of both grey and peer-reviewed academic literature. It builds on the material and evidence synthesized in the toolkit's background section and highlights findings from the data extraction table in the Appendix.

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.

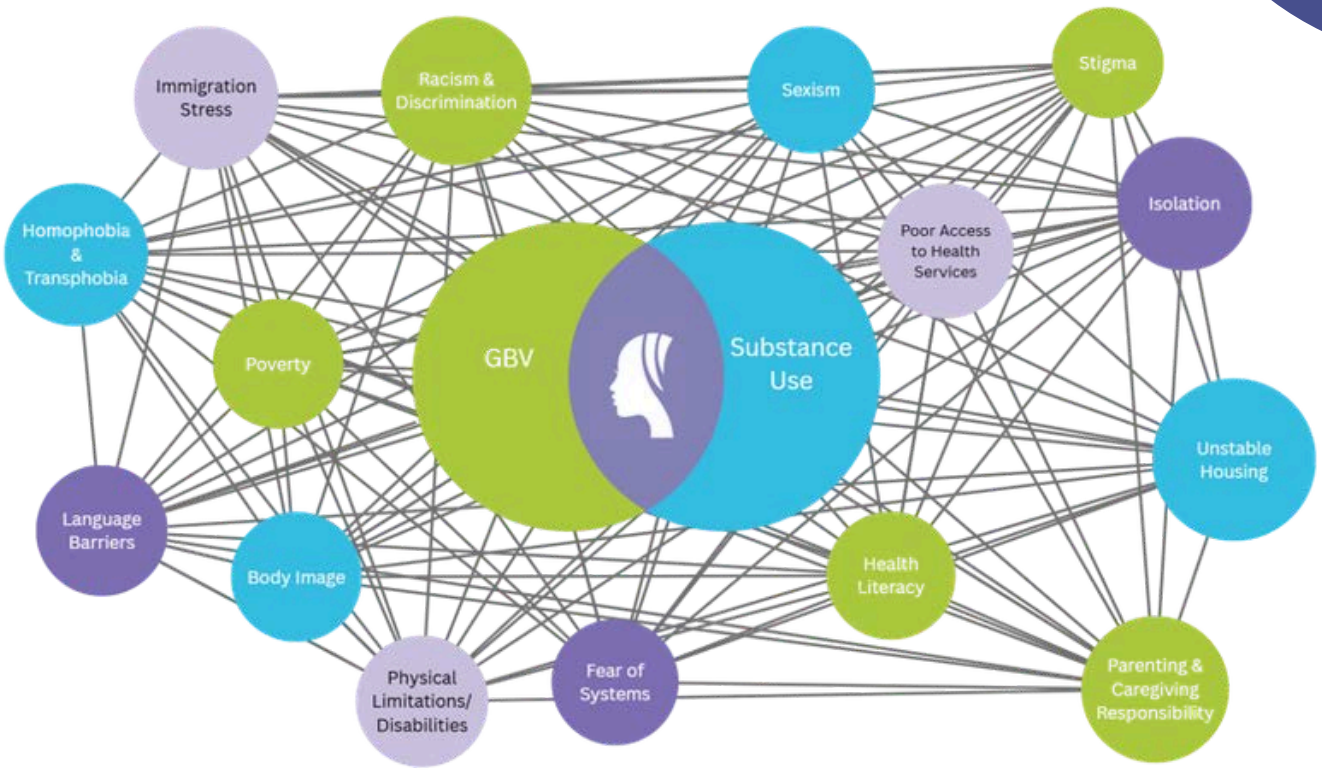
Respecting women’s autonomy and supporting their ability to make their own choices are essential components of trauma-informed practice and help ensure that services remain collaborative and empowering (Hovey et al., 2020).

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:

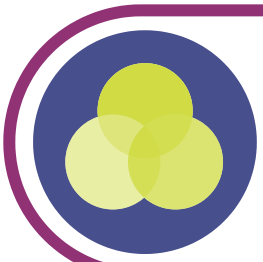


Safety and substance use do not exist in a vacuum. Racism, poverty, housing insecurity, colonial harms, immigration-related stress, and minority stress can narrow choices and increase risk.

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)*

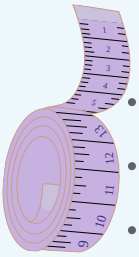
Intersectional Perspective

- 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).

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

1. **Awareness:** "Parenting often occurs under significant scrutiny, and fear of systems can be very real."
2. **Safety & Trustworthiness:** "Let's review confidentiality and your choices before we begin."
3. **Choice/Collaboration/Connection:** "What are your hopes for your children, and how can we align care with those goals?"
4. **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.

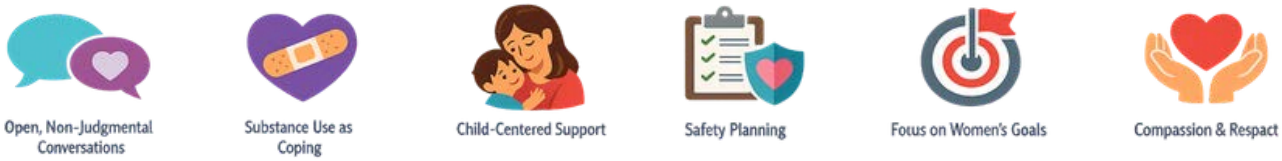
Women experiencing gender-based violence and substance use during pregnancy or while parenting may delay or avoid seeking help due to fears of judgment, child welfare involvement, or punitive responses. When services are perceived as unsafe or punitive, women may protect themselves and their children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

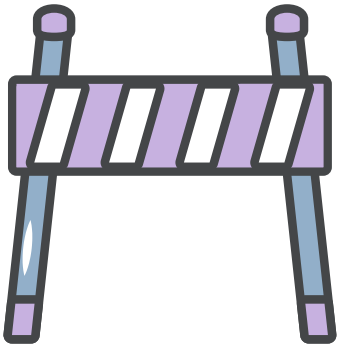


Parenting Capacity and Protective Factors: Do not assume that a parent who uses substances is incapable of parenting safely. Consider the full picture, including safety efforts, return-to-use prevention plans, and child protection strategies. Children may be removed due to GBV and, in some cases, returned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

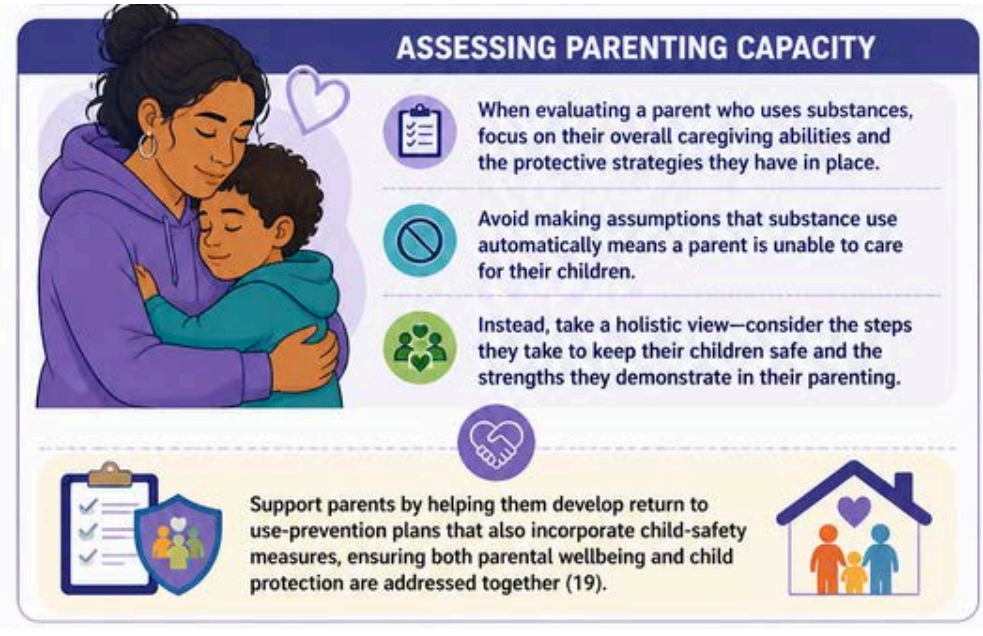
PRACTICE IMPLICATIONS

- 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).



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)

1. **Awareness:** "Whose knowledge is guiding this conversation? What histories are shaping today?"
2. **Safety & Trustworthiness:** "What would cultural safety look like for you in this space?"
3. **Choice/Collaboration/Connection:** "Who would you like involved (e.g., Elders, peers, or support people)?"
4. **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?"

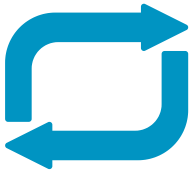
A. KEY PATTERNS AND DISPARITIES (Why Inclusion Matters)

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

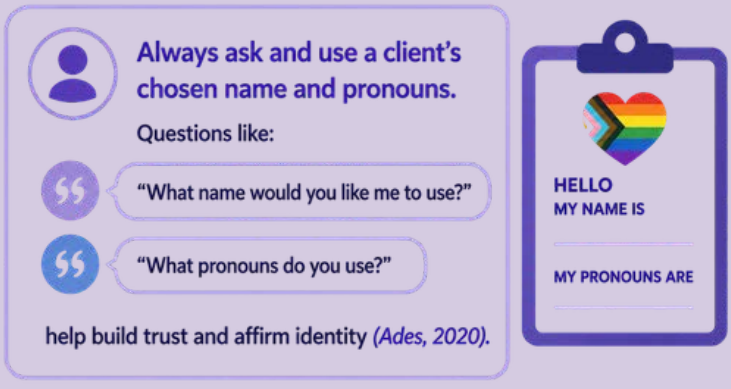
1. **Move beyond cis-heteronormative models.**
Programs built around cisgender, heterosexual assumptions often exclude or misrepresent transgender clients. Services should instead be grounded in the intersectional experiences of transgender people, particularly those living with multiple forms of marginalization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



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).

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).

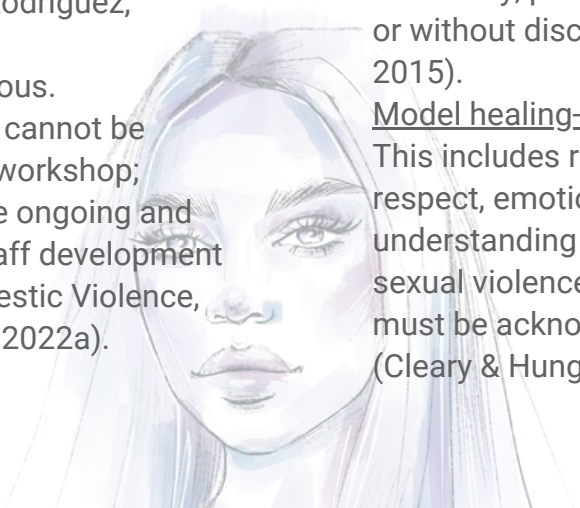
Use diagnostic labels carefully.
Language matters, and diagnostic terms that label survivors as "disordered" can sometimes overlook the fact that these reactions are normal responses to trauma rather than signs of personal pathology (Bailey et al., 2019).

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.

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)

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

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 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

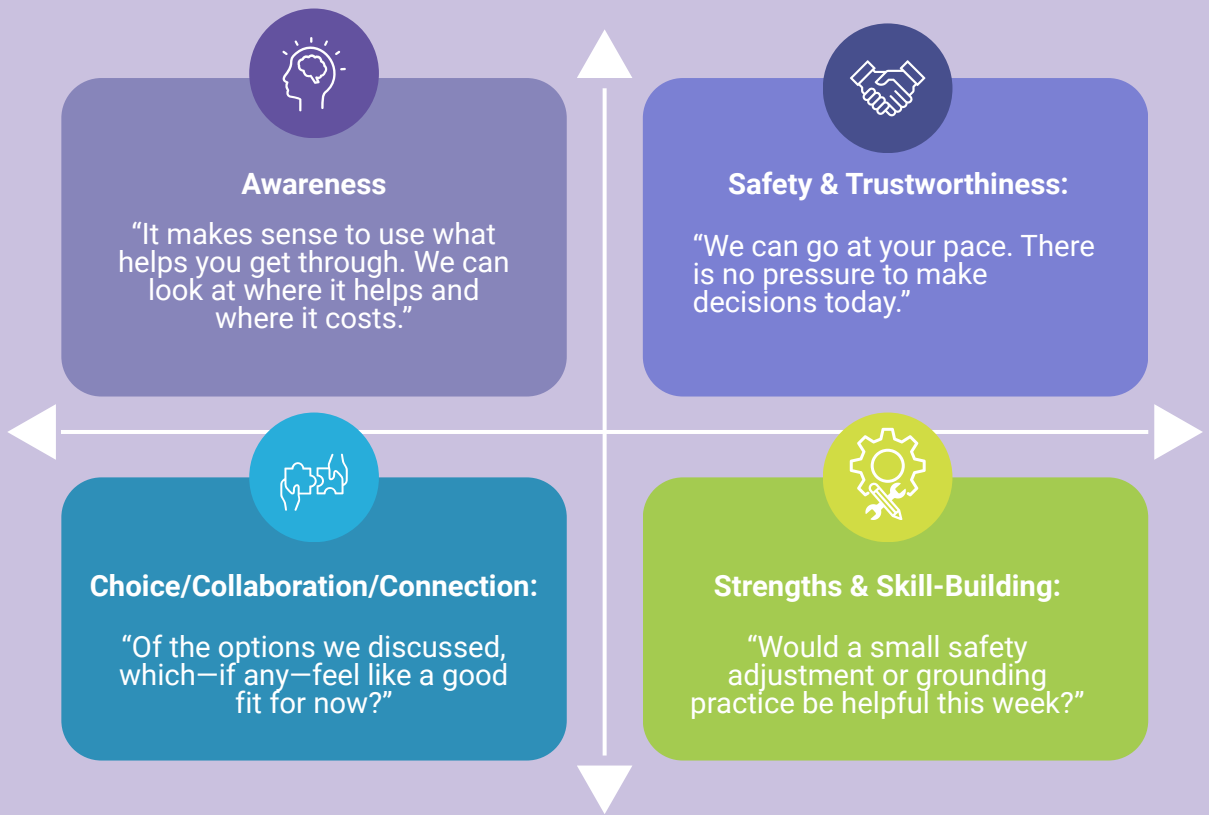
1. **Awareness:** "We ask everyone about safety and substance use to make support accessible and routine."

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

3. **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?"

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

4 ANCHOR APPROACH TO PROVIDING BRIEF SUPPORT



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:

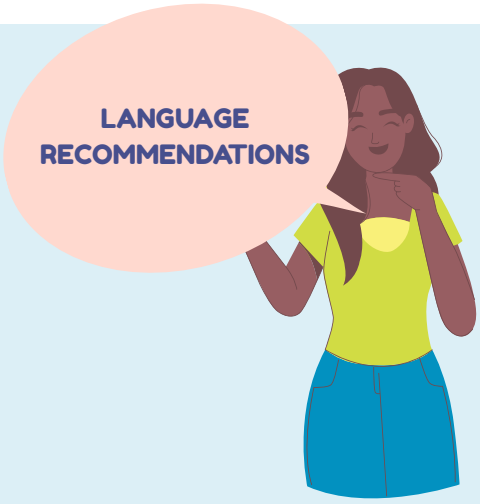
CAGE (Cut down, Annoyed, Guilty, Eye-opener)

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.

DID YOU KNOW?

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."

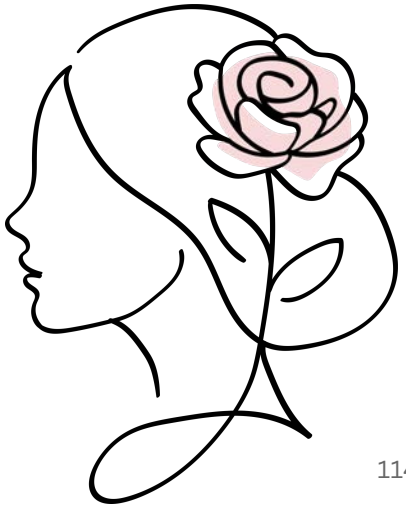
10.6 BEST PRACTICES FOR SUBSTANCE USE SCREENING IN IPV SETTINGS

- **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

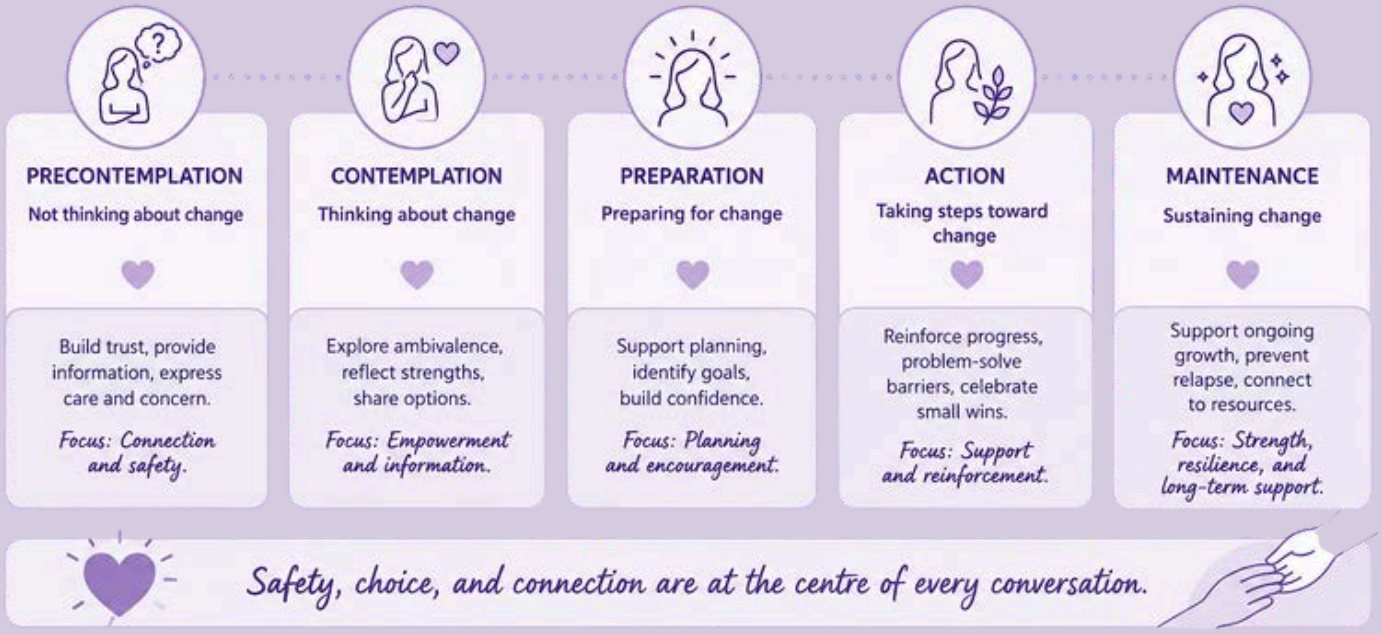
The Transtheoretical Model of Behaviour Change can guide interventions by assessing clients' stages of change related to substance use and IPV, helping providers tailor goals and strategies accordingly.

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



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

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- Recognize the importance of ensuring that services are both domestic violence (DV)- and trauma-informed.

BRIEF INTERVENTION

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

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.

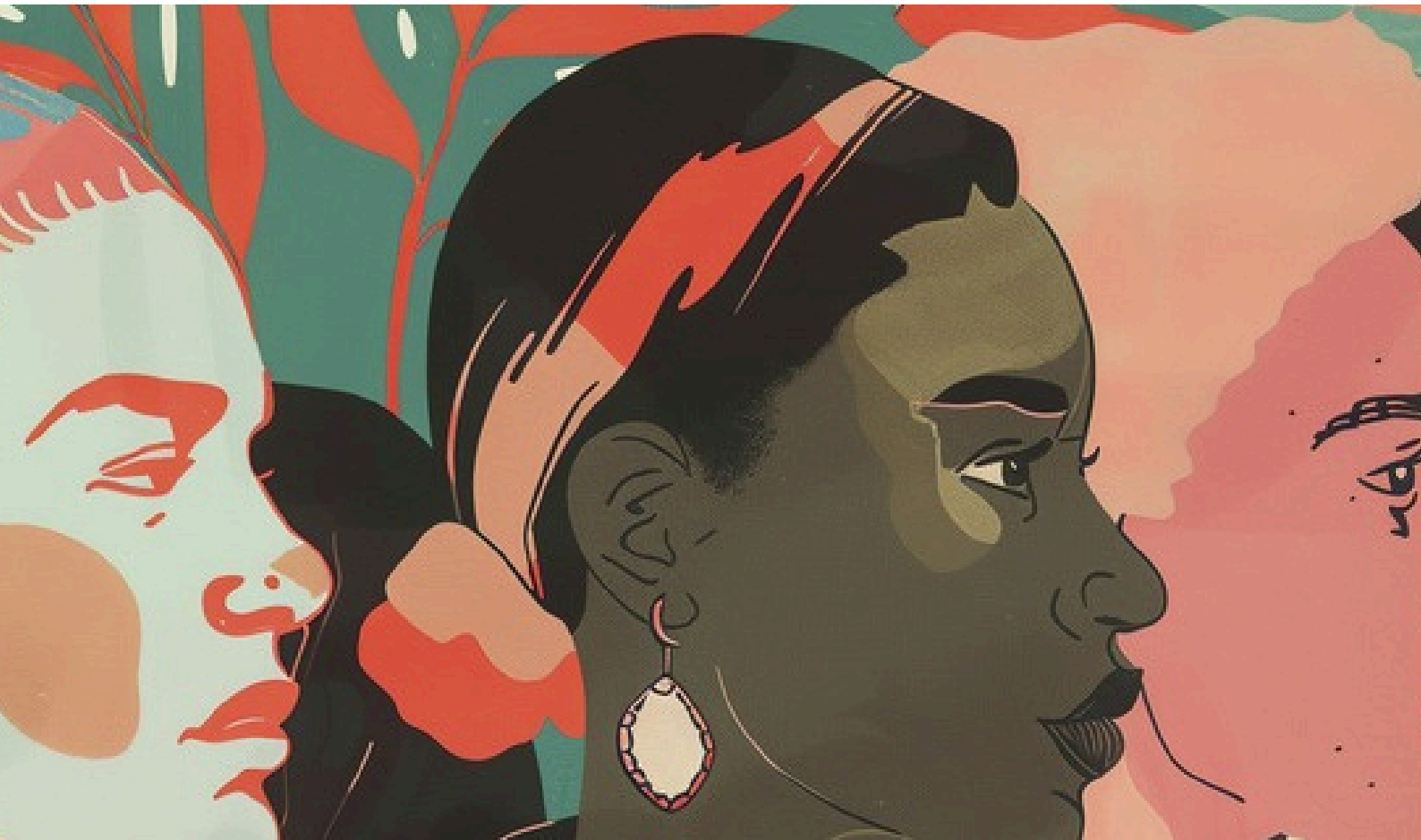
Develop Discrepancy: Help clients recognize the gap between current behaviours and personal values.

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

DID YOU KNOW?

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.

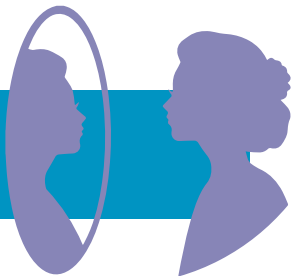
CONTINUUM OF SUBSTANCE USE IN GBV CONTEXTS — STRENGTHS-BASED, RELATIONAL PRACTICE (EQUIP / CEWH / TVIC-ALIGNED)

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?"

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

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.

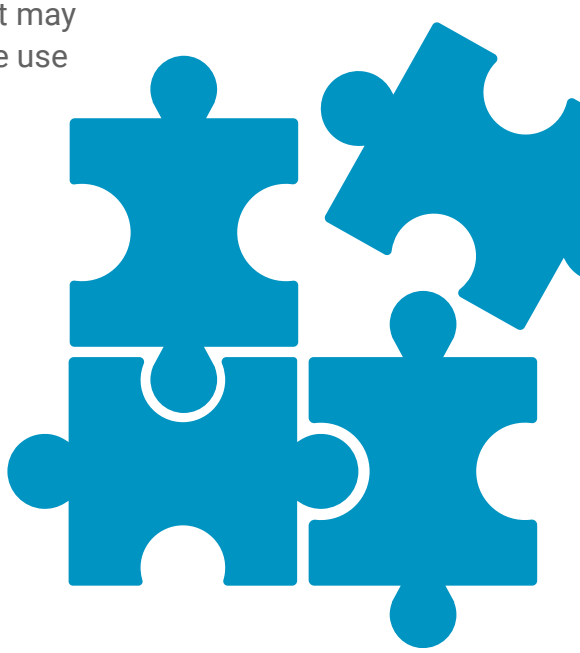
Follow-Up After Referrals

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.

1

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").

2

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

3

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.

4

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).

5

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

6

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.

7

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

8

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

1

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."

2

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.

3

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).

4

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

1

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., Gutlvia, K. M., Midlo, M., J. Wetle, T F., Banney. M. L. Tape. C. & Ziornick. C. (2018) II 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--220) https //dol org/10.16.11/1946-636017.2 193

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

1. **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.

2. **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.**

3. **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.

CHAPTER 11

Intersectoral and Intersectional Considerations & Recommendations

11. INTERSECTORAL AND INTERSECTIONAL CONSIDERATIONS AND RECOMMENDATIONS

Intersectoral collaboration is relational work. Women often navigate housing, legal systems, income supports, child welfare, primary care, and community support services simultaneously. When providers coordinate introductions, explain what to expect, and share information transparently and with consent, women experience systems as safer and more predictable. Co-location, warm transfers, and peer accompaniment reduce retelling and signal that services will stay with her through starts, stops, and returns. These approaches are grounded in relational, woman-centred, and trust-building practices (Centre of Excellence for Women's Health; BC Society of Transition Houses).

Women who live at the intersection of gender-based violence (GBV) and substance use often have to navigate multiple systems—primary care, emergency and public health services, housing and shelter intake, income assistance, child welfare, legal aid or family court, immigration, and sometimes criminal court.

Whether those systems recognize the whole context of her identity, community, culture, trauma history, safety, caregiving, income, disability, and migration often determines what comes next: a safe connection and some breathing space, or another door closed and a growing sense that help makes things worse.

Canada's own frameworks call us to be better. Trauma- and violence-informed care (TVIC) reminds us that violence and trauma are not side notes; they are core social determinants of health and service use. GBA Plus (Gender-Based Analysis Plus)/SGBA+ (Sex- and Gender-Based Analysis Plus) asks us to design for diversity and inequity from the outset, with disaggregated data and accountability. Together, they offer a practical way to make intersectoral care safer, more consistent, and more equitable.

Jean Tweed Centre Client

"I was lost, out of control, and suicidal. I now feel optimistic and heartened that there is a light at the end of the tunnel. The comprehensive, holistic, and integrated suite of services I have received has been invaluable in meeting my specific needs."

Women's journeys cross many systems. Safety depends on whether those systems work together as one.

- Document neutrally and plan follow-up within 3–7 days.
- Share only what she consents to and confirm next steps and timelines.
- Arrange a warm transfer (e.g., GBV services, housing, legal supports, primary care, social services, peer support, or child and family supports).
- Identify red flags related to safety, traumatic brain injury (TBI), coercion, and withdrawal risk.

PRACTICE PEARL:

All interventions addressing GBV and substance use should operate through an intersectional lens, addressing structural violence and systemic oppression.

Bohrman, C., Tennille, J., Levin, K., Rodgers, M., Rhodes, K. (2017). Being Superwoman: Low Income Mothers Surviving Problem Drinking and Intimate Partner Violence. Journal of Family Violence, 32, 699-709. DOI: 10.1007/s10896-017-9932-5.

Fear of systems shapes safety choices. Do not assume police or child welfare involvement increases safety. When racism, substance use, or prior system contact is present, prioritize non-punitive, voluntary supports that centre survivor choice and minimize system escalation.

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

11.1 HOW INTERSECTIONALITY CHANGES WHAT WE DO

Intersectionality is not a theory for the margins; it is everyday practice in GBV and substance use care for women experiencing GBV and substance use. It takes into account the multiple intersecting dimensions that affect, and at times compound, inequity and barriers to accessing needed care and services.

An intersectional lens for understanding the compounding and intersecting factors that drive inequitable access to support requires us to factor those considerations into how we organize clinics, shelters, court supports, and pathways to safety and support, and to measure whether the changes work for the people most affected.

Myth-busting intersectionality

Myth: Intersectionality is an add-on.

Fact: It is how we design for real-world risk and access (transport, language, identity, and income).

PRACTICE PEARL:

Gender-specific approaches are essential: treatment should consider sex-specific challenges, victimization experiences, and the moderating effects of gender on substance use and recovery.

Health and treatment differences:

- Women experience more severe opioid withdrawal symptoms than men.
- Women experience higher opioid-related cravings and overdose risk.
- Women are less likely to be prescribed Narcan following a suspected overdose and less likely to receive a direct referral to treatment or follow-up after an emergency department (ED) visit.

Huhn, A., Dunn, K. (2020). Challenges for Women Entering Treatment for Opioid Use Disorder. Current Psychiatry Reports 22(76). Tubman, J. G., & Galo, G. E. (2025). Lifetime adversity and risky substance use among transgender emerging adults: Selected interventions and clinical social work practice. Clinical Social Work Journal, 53, 32–42. https://doi.org/10.1007/s10615-024-00967-6

Motz, M., Andrews, N. C., Bondi, B. C., Leslie, M., & Pepler, D. J. (2019). Addressing the impact of interpersonal violence in women who struggle with substance use through developmental-relational strategies in a community program. International Journal of Environmental Research and Public Health, 16(21), 4197. https://doi.org/10.3390/ijerph16214197

11.2 HEALTH, EMPLOYMENT, AND EVERYDAY SERVICES: THE ACCESS GAP

In the intake room or during an admission phone call, access is often determined by language, health literacy, paperwork, and how we ask about what women need most and their strengths. Women juggling GBV and substance use describe avoiding care because of stigma, fear of child welfare involvement, or prior experiences of being dismissed or disbelieved. TVIC and equity-oriented care demonstrate tangible actions that can improve outcomes. For example, introduce “screening” by asking about substance use and GBV as routine for everyone; check privacy before asking; mirror preferred names and pronouns; explain what will (and will not) be documented; and design spaces and policies that feel safe for people who have every reason not to trust systems that may have broken their trust.

At the policy level, Canada’s National Action Plan to End GBV and the federal GBV Strategy call for survivor-centred supports and better intersectoral coordination—across health, social infrastructure, and justice—so that people do not have to choose between safety, treatment, employment, and care of children. Sex and Gender-Based Analysis Plus (SGBA+) guidance in federal departments expands this to equitable program design, disaggregated data, and accountability —mechanisms that turn good intentions into durable access.

Employment and income are determinants of health. Survivors report job loss due to missed shifts and court dates; others fear that disclosure to an employer could cost them their jobs. Equity-oriented policies—from paid leave for violence to flexible scheduling in substance use disorder care and employer education—reduce harms that otherwise are addressed downstream in emergency rooms, shelters, and child protection systems.

PRACTICE PEARL:

External barriers, such as judgmental attitudes from service providers and social stigma, can lead to self-stigma. Isolation may lead women to withdraw from public life and continue using substances to forget, suppress, or reduce negative feelings arising from shame.

Schamp J, Vanderplasschen W, and Meulewaeter F (2022) Treatment providers' perspectives on a gender-responsive approach in alcohol and drug treatment for women in Belgium. Front. Psychiatry 13:941384. doi: 10.3389/fpsyt.2022.941384

11.3 LEGAL AND JUSTICE SYSTEM IMPACTS: PATTERNS, NOT ONE-OFFS

Women experiencing both gender-based violence (GBV) and substance use are often subjected to coercive control long before any assault is reported. This can include surveillance, threats, isolation, economic abuse, and the forced or sabotaged use of substances, as well as post-separation litigation tactics that drain time and financial resources. Canadian family law increasingly recognizes patterns of behaviour—not isolated incidents—as constituting family violence. For frontline documentation and advocacy, this underscores the importance of recording "course of conduct" evidence (e.g., ongoing monitoring, financial control, technology-facilitated harassment), rather than focusing solely on physical injuries.

Criminal law reform in Canada is also evolving. Bill C-332, which addresses coercive control, passed the House of Commons and advanced to the Senate in 2024, signalling a shift toward earlier intervention in patterns of harm. In 2025, federal proposals expanded on this direction, aiming to criminalize coercive control as part of a broader legislative framework. At the same time, Canadian scholars caution that without careful implementation—including training, public legal education, and safeguards within immigration and family law systems—criminalization may not adequately protect those at greatest risk and could lead to unintended consequences.

PRACTICE PEARL:

External judgment and societal expectations can shape how women choose to respond, often leading them to carefully manage their perceived image to protect their safety, dignity, and sense of control. In unsupportive environments, women may face additional barriers to disclosing gender-based violence or seeking help.

Alcantud, P., Campdepadros-Cullell, R., Fuentes-Pumarola, C., Mut-Montalva, E. (2020). 'I think I will need help': A systematic review of who facilitates the recovery from gender-based violence and how they do so. Health Expectations 24(1), pp. 1-7. https://doi.org/10.1111/hex.13157

11.4 HOUSING AND HOMELESSNESS: WHEN SAFETY MEANS MOVING AGAIN (AND AGAIN)

Housing is where GBV and substance use intersect most painfully. Women often reduce risk by moving repeatedly—to a friend's couch, a motel, a new partner's home, or a shelter two cities away.

Much of this reflects hidden homelessness and is therefore undercounted. Statistics miss the nights spent avoiding the streets by entering unsafe arrangements. Gender-responsive evidence points to what works: coordinated pathways across GBV services, housing programs, primary care, and income supports, with TVIC at the centre so the journey out of violence is not itself dangerous.

Canadian analyses emphasize tailored, women-centred housing (and adaptations of Housing First for women and gender-diverse people), along with rapid, low-barrier access from hospitals, GBV services, and courts. These approaches reduce the "choice" between staying with a person using abusive behaviours, engaging in survival sex, or returning to substance use in unsafe contexts. Women-focused guidance also highlights that mother–child models that stabilize housing and support recovery and parenting are key to sustainable exits.

PRACTICE PEARL:

Discrimination is a lifelong adversity that many people experience. It is essential to have open conversations with clients about how discrimination might be connected to their experiences of GBV and/or substance use.

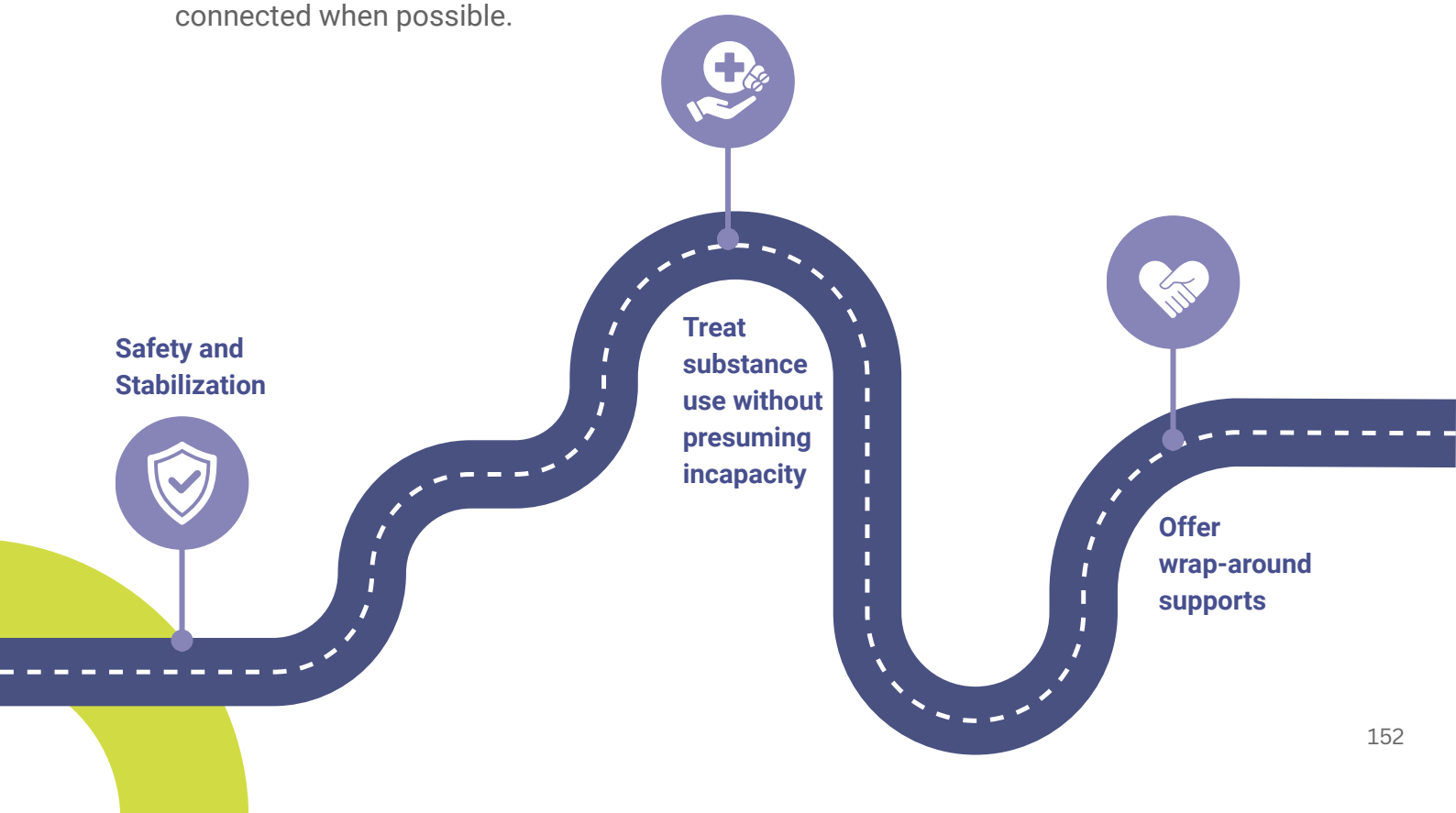
Tubman, J. G., & Galo, G. E. (2025). Lifetime adversity and risky substance use among transgender emerging adults: Selected interventions and clinical social work practice. Clinical Social Work Journal, 53, 32–42. https://doi.org/10.1007/s10615-024-00967-6

11.5 CHILD-WELFARE: SEPARATING RISK FROM SUPPORT

When GBV and substance use intersect, women often anticipate that seeking help could lead to a child welfare report. Fear is not unfounded; across Canada, surveillance-heavy responses can conflate perpetrator risk with a mother's coping (including substance use as a trauma response).

TVIC offers a different path: begin with safety and stabilization; treat substance use without presuming incapacity; offer wraparound supports (parenting, attachment-based care, kinship options) that keep children safe and keep families connected when possible.

The MMIWG Calls for Justice include specific obligations for social workers and child welfare systems: uphold rights, reduce removals, and implement culturally grounded services that reflect community definitions of well-being. In practice, that means Indigenous-led planning, accountability to communities, and pathways that avoid turning help-seeking into punishment.



11.6 INDIGENOUS WOMEN AND 2SLGBTQQIA+ PEOPLE: HONOURING SELF-DETERMINATION

The National Inquiry into MMIWG names the colonial roots of violence and calls for transformative, intersectoral change and systems that honour Indigenous jurisdiction and knowledge across health, justice, housing, social services, and child welfare. The Inquiry also recognizes the disproportionate violence experienced by Indigenous women, girls, and 2SLGBTQQIA+ people, and the importance of affirming gender diversity, cultural identity, belonging, and self-determination in all responses.

For care workers, the implications are immediate: partner with Indigenous leadership; embed culture, land, language, and Elders; create inclusive and affirming spaces for Indigenous women and 2SLGBTQQIA+ people; and treat self-determination as an evidence-based safety practice.

11.7 WHAT COORDINATED, EQUITY-ORIENTED SYSTEMS LOOK LIKE (CANADA'S LEVERS)

Canada's National Action Plan to End GBV (five pillars) and the federal GBV Strategy (three pillars) provide a shared framework for provinces, territories, and municipalities. Provincial action plans (e.g., Ontario STANDS) and local community action plans show how intersectoral tables can drive no-wrong-door pathways. Sector-specific guidance (e.g., women's substance use treatment and recovery) and anti-racism/anti-oppression frameworks help organizations turn intersectionality into daily practice—across spending power, hiring, space, schedules, data, and partnerships—so the system reflects whom it serves.

11.8 RECOMMENDATIONS

Make it a single system on the ground. Establish local GBV and substance use tables with decision-making authority to map no-wrong-door pathways (health, GBV, housing, legal, child welfare, settlement, Indigenous partners). Track equity using disaggregated data and lived-experience feedback.

Hard-wire TVIC and SGBA+ into policy and programs: standard privacy checks, non-stigmatizing documentation, interpreter access, flexible appointments, staff debriefing and supervision, and warm-transfer expectations across agencies.

Health and Substance Use (SU) services: Offer universal SBIRT with LIVES and harm reduction; ask about substance-use coercion and strangulation/traumatic brain injury (TBI); embed mother–child and women-centred programming to reduce care, work, and parenting conflicts.

Housing: Create rapid, women-centred pathways (including Housing First adaptations) from hospitals, courts, and GBV services; measure hidden homelessness and successful contacts, not just referrals made.

Justice & child welfare: Train on coercive control; document patterns; align family, criminal, immigration, and child welfare systems to avoid penalizing help-seeking; if criminal reforms proceed, pair them with training and safeguards to prevent unintended harms.

Indigenous leadership: Support Indigenous-designed services and local implementation of the Calls for Justice with transparent accountability.

Chapter 12.
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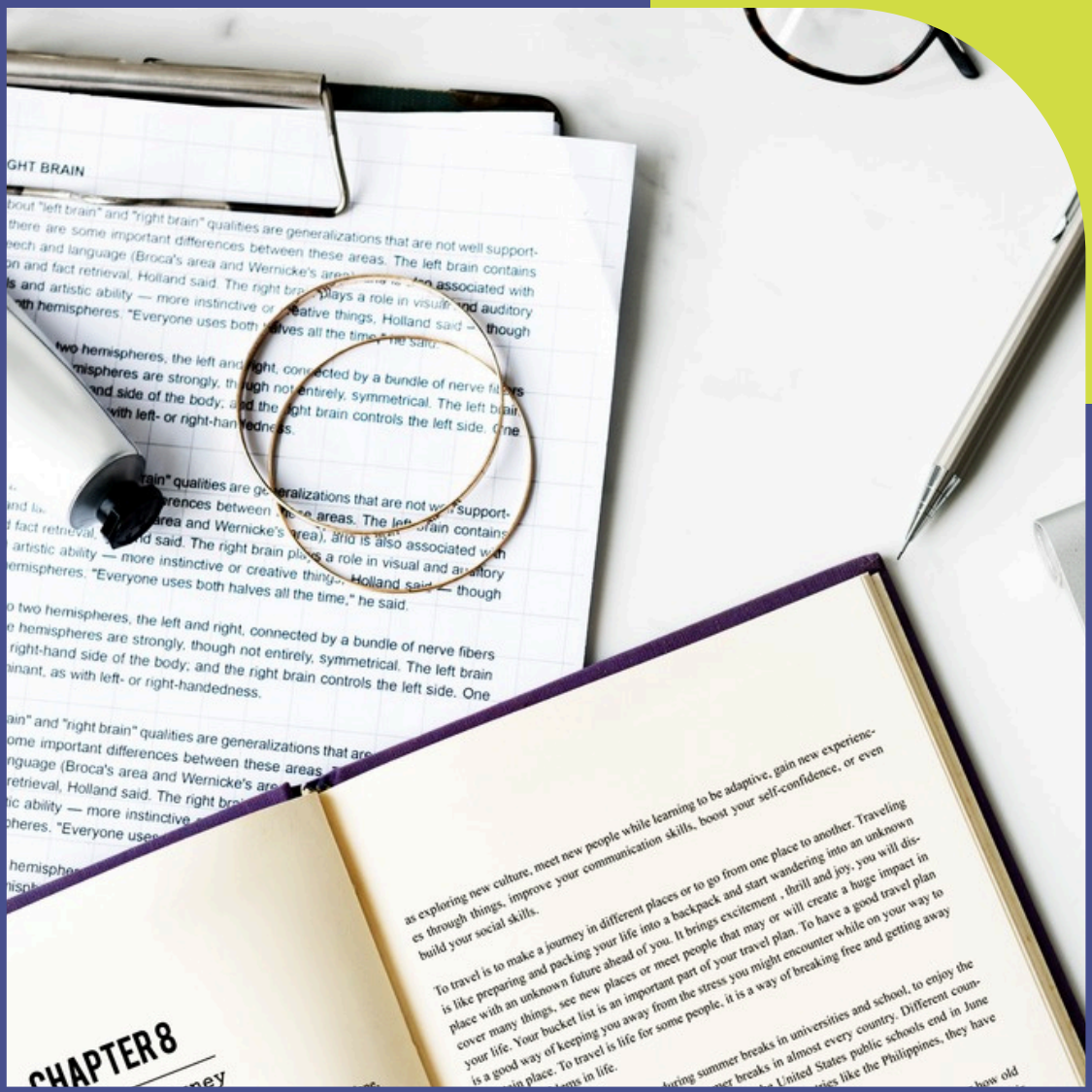

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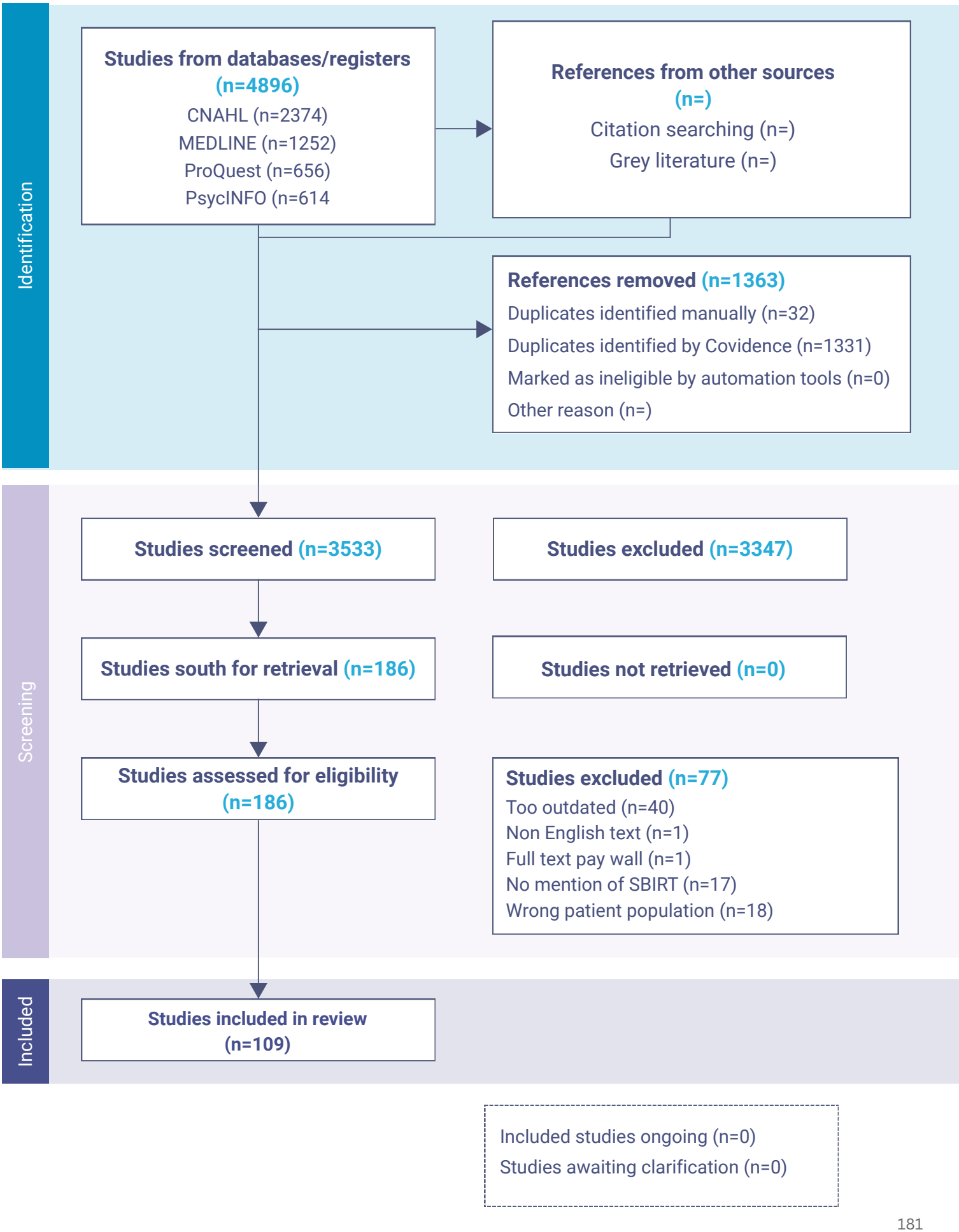
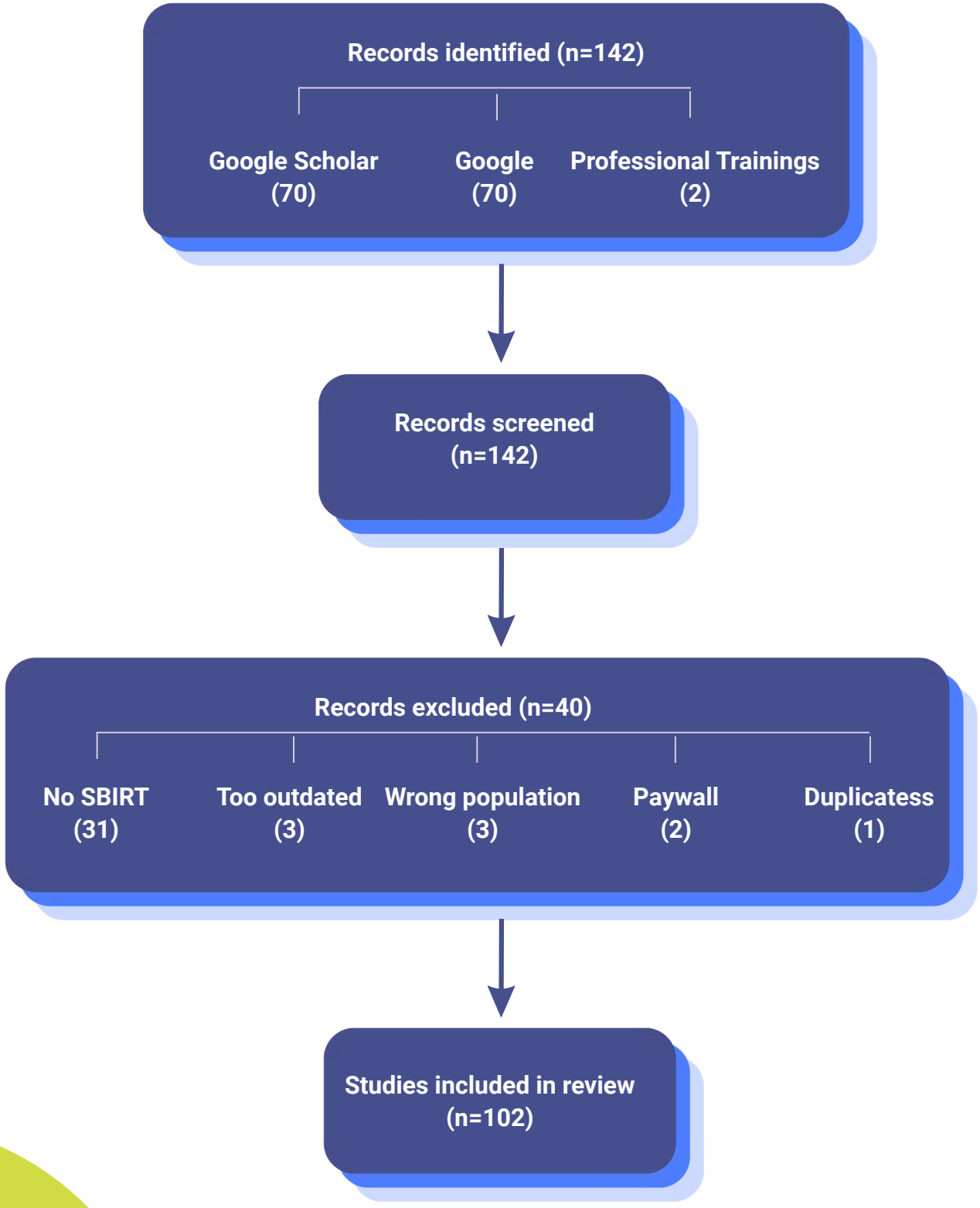
Chapter 13
Appendices

Appendix A:
PRISMA DIAGRAM PEER REVIEWED LITERATURE



Appendix B:
PRISMA DIAGRAM GREY LITERATURE SEARCH



Appendix C:
Safety Plan
Immediate Safety Needs Related to Gender-Based Violence and Substance Use

This safety plan is intended to support women in identifying immediate safety needs, supportive connections, and practical strategies during times of crisis, heightened risk, or uncertainty. Safety planning looks different for everyone. Individuals are encouraged to complete only the sections that feel safe and relevant to them.

---

1. My Support Network

(Examples: trusted friend, counsellor, case manager, healthcare provider, Elder, peer support, cultural or spiritual support, community organization, shelter staff, or support group)

Name / Service	Phone Number or Contact Information	How They Support Me

---

2. Emergency Bag / Preparing for a Quick Exit

Possible items may include: • Change of clothes
• Cash or prepaid card
• Snacks and water
• Phone charger
• Keys
• Identification and copies of important documents
• Medications

• Emergency contact information
• Comfort items for children
• Transportation cards or bus fare

Important: If keeping an emergency bag at home could increase risk or escalate harm if discovered, consider alternative safety options.

Items that may be important for me to include:

_____

_____

_____

3. Plan for Immediate Danger

(If I feel unsafe, threatened, controlled, or at risk of harm)

If possible, can I move to a safer area where:
• I may be able to leave more easily?
• Someone may hear me?
• There may be fewer objects that could be used to cause harm?

For example, avoiding isolated spaces or rooms with weapons or sharp objects.

If I cannot leave the house, I may try to move to:

_____

If I am able to leave, a safer place I could go is:

_____

Important items I may want access to:

_____

Emergency contacts:

_____

4. Crisis Support

(If I need immediate support and cannot reach someone I trust)

• Local emergency services: _____

• 24/7 Crisis Support: Call or text **211** or call **911** in an emergency

• Local women's, violence, mental health, or substance-use support services:

_____

_____

5. Harm Reduction and Safety Checklist

- Keeping my phone charged and accessible
- Saving emergency contacts in my phone
- Eating regularly and staying hydrated
- Taking medications as prescribed
- Avoiding using substances alone when possible
- Trying to avoid mixing substances
- Carrying Naloxone or knowing where to access it
- Having transportation money or a safer ride plan
- Letting someone I trust know where I am, if safe to do so
- Planning for children, pets, or dependents if needed

Other things that may help increase my safety:

_____

_____

_____

A Safer Place to Keep This Plan

Examples may include:
- With a trusted person
- In a password-protected phone or email account
- Hidden among personal documents
- At a community agency or support service

_____

_____

The Jean Tweed Centre

JTC

For Women & Their Families

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