

COMMITTED TO SAFETY FOR ALL SURVIVORS: GUIDANCE FOR DOMESTIC VIOLENCE PROGRAMS ON SUPPORTING SURVIVORS WHO USE SUBSTANCES

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Organizational Policies and Practices that Promote Safety Within Program Settings

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

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

Practice: Survivors are neither expected nor required to disclose their substance use to staff. Instead, staff focus on setting the stage for safe conversations about substance use by:

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

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

- Policies are communicated in language that is understood by the survivor (both verbally and in writing).
- Policies are clearly connected to creating an environment of safety (i.e., policies focus on safety, not changing or controlling a survivor's choice to use substances).
- Survivors are included in cultivating an environment of safety (i.e., safety is not something that only staff provides for the program; rather, everyone has a role in creating a safe environment).

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

- Substance use in and of itself isn't cause for service restriction or program exit.
- Programmatic consequences for substance use are experienced as punitive and contribute to harmful

dynamics of power and control within advocacy relationships.

- When a survivor who uses substances experiences a natural negative consequence associated with use (such as being denied employment due to testing positive on a drug test as part of a hiring process), advocacy staff provide empathetic and nonjudgmental support to the survivor in ways that the survivor defines as helpful. This fierce alignment with a survivor who is experiencing harms related to substance use provides the kind of space and support they need to be able to consider decisions about how to improve their situation.

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

- Programs can help prevent crisis by creating stable access to food and water. Certain medications and/or medical conditions may require eating outside of established mealtimes. Regardless of substance use, having the ability to satisfy one's hunger or eat for general well-being is essential to a sense of safety. This is especially important to a person's safety and well-being when they are using substances.
- If there is a specific behavior that is creating a safety concern within the program, staff offer support around the specific behavior (rather than focusing on whether or not substance use is involved).
- Staff partner with each survivor in creative and flexible solution-finding to support them in addressing the behavioral concern. If a survivor seems to be experiencing emotional dysregulation, staff engage with them in a soothing environment and offer self-soothing and co-regulation strategies.
- Once the immediate safety need has been resolved, staff debrief with each survivor, seeking their input on what happened, responding with empathy, and offering support to collaboratively craft solutions that can address their personal needs as well as the program community's safety needs.
- If a child welfare report is required, use as much transparency as possible, and give the survivor the choice to be present and involved in making the report.
- As advocates, it is important to recognize that punitive approaches are never warranted. Instead, to offer support and resources. It may be helpful to approach situations with the perspective that someone is experiencing a need (versus breaking a "rule" or doing something wrong). For more information, please see NCDVTMH's online webinar series *Trauma-Informed Responses to Emotional Distress and Crisis*.

Policy: Services are provided on a voluntary basis.

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

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

substance use.

- Staff offers support for survivors in caring for and protecting their children, including safety planning in regard to substance use, and planning for children's well-being.
- Legal advocacy services include child welfare advocacy (when desired).

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

- Staff offers support, resources, and empathic responses when survivors who identify as being in recovery and/or sober experience cravings to use or feel distress in regard to someone else's substance use.
- Program provides support groups that honor and respect the diversity of recovery goals, ranging from safer use to complete abstinence from all substances.
- Staff are trained on overdose prevention and response and overdose prevention education and materials are offered to all survivors.
- Program makes naloxone kits available in communal areas as well as has them easily accessible in staff areas (similar to fire extinguishers and first aid kits).
- Program is aware of safer bathroom practices and makes these accommodations as they are able to.
- Staff are knowledgeable of and able to collaborate with peer-led mutual aid groups and recovery community organizations. If desired by survivors, programs could consider having a well-vetted volunteer facilitate a mutual aid group on-site or can have a staff member trained to facilitate mutual aid groups (certain kinds of groups offer facilitator trainings, other groups must always be facilitated by a member of that mutual aid tradition). See appendix for more information and resources on mutual aid groups.
- If/when a survivor chooses to access substance use treatment and/or recovery services, staff provides information on available resources, advocates for access, supports active service connection and helps to anticipate and address any safety concerns that may come up in accessing these services. Safe and stable access to Medication Assisted Treatment (i.e., methadone, buprenorphine, etc.) is especially important for people with histories of opioid use.
- Program offers resources and support to facilitate adherence to treatment/recovery services and/or medication assisted treatment/recovery that survivors can request if they elect to access any kind of formal treatment/recovery resources.
- Staff has an understanding of how partners who seek to exert power and control over survivors often attempt to jeopardize a survivor's attempts to access formal treatment/recovery supports (including controlling access to medications) and offer support with strategizing safe ways to access treatment/recovery resources.
- Administrators and organizational leaders make efforts to increase access to substance use treatment and recovery services for survivors, exploring all available options. Partner with treatment providers to increase their awareness of the particular risks survivors face and to craft creative solutions including: telehealth for Medication Assisted Treatment (MAT) and other treatment services, advocating for survivors to pick-up methadone weekly and store their medication on-site (to avoid barriers to attending daily methadone services), and more. MAT programs are often concerned about misuse of medications used in addiction treatment but are generally unaware of the risks survivors face from their abusive partners when MAT programs require attendance at routine (often daily) appointments. Collaboration, cross-training, and advocating within systems are all needed in order for survivors to be able to safely access treatment resources.

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

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

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

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

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

- Mandatory drug testing is not aligned with an ACRTI approach and not considered an acceptable practice for DV programs. It is, in fact, harmful to survivors whether or not they use substances.
- Mandatory drug testing would not be aligned with current requirements for voluntary services, that expressly prohibit shelters from screening based on sobriety or requiring participation in services such as counseling as a condition for accessing emergency shelter, found in Family Violence Prevention and Services Act (FVPSA) CFR 45 Part 1370. Additionally, transitional housing funded through the Office of Violence Against Women has a similar requirement that support services be voluntary (and not a condition for housing), found in 34 U.S.C § 12351 (b)(3)(C).
- According to the American Society for Addiction Medicine, drug testing should not be used as a tool of punishment or taking away privileges (ASAM, 2017).
- Mandatory drug testing is physically, emotionally, and socially coercive as well as humiliating. This practice implies that a person is only deserving of safety if they are free from substances AND that the assumption is that the person cannot be trusted to tell the truth, so they must surrender a bodily fluid in order to prove they do not use substances.
- The practice of mandatory drug testing can easily revictimize a survivor because of the ways it replicates substance use coercion.
- Drug testing is an imperfect tool at best and a coercive tool at worst. The only information a drug test can show is whether or not there is enough of a substance in a person's body for the test to detect. Drug test results do not reflect a person's pattern of substance use, says nothing about whether their substance use poses any risks, and cannot diagnose a substance use disorder (which is not within the purview of DV programs unless it is also licensed to provide treatment) (ASAM, 2017). There are times an individual may not test positive for substances but would qualify for treatment services (if they were interested in this resource).
- However, as long as there is no punishment or coercive practice associated drug testing, it can be helpful to have self-testing drug test kits available for those who request it. Some survivors may find it helpful to privately self-test as part of their preparation for job searching or court appearances.

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

If your program requires drug testing survivors, take some time to reflect on why that might be. When did your program start drug testing? Has it always been this way?

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

What function does it serve in your program?

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

Drug testing is not a substitute for trauma-informed crisis prevention and response policies and skills.