

HEALTH

# eBULLETIN

DVAM  
2018



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# LETTER FROM GUEST EDITOR DR. CAROLE WARSHAW

*Carole Warshaw, MD is the executive director of the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH), where they offer an array of training and technical assistance resources to support the domestic violence, mental health, substance use, and child welfare fields in creating accessible, culturally responsive and trauma-informed services for DV survivors and their children.*



In this Domestic Violence Awareness Month edition of the Health e-Bulletin, we focus on the experiences, concerns, and promising approaches that have been emerging at the intersections of domestic violence, substance use, trauma, and the opioid epidemic. Research has consistently documented that abuse by an intimate partner increases a person's risk for developing a range of health and mental health conditions including depression, PTSD, suicidality, chronic pain and substance use.<sup>1-5</sup> Some of these conditions are the direct result of physical and sexual violence; others are related to the traumatic psychophysiological effects of ongoing abuse. Not surprisingly, research has also documented high rates of DV among people seen in substance use disorder treatment settings, including methadone treatment programs, as well as high rates of substance use among people seeking DV services, underscoring the need for more integrated approaches to substance use and DV.

Less well recognized, however, are the ways that people who use harm and violence to control their partners engage in coercive tactics targeted toward their partner's mental health or substance use as part of a broader pattern of abuse – tactics referred to as mental health and substance use coercion. While DV survivors may use alcohol or other drugs to cope with emotional trauma or chronic pain,<sup>6</sup> they may also be coerced into using by an abusive partner who then controls their supply and uses their substance use to further their control.<sup>7</sup> Surveys conducted by the National Domestic Violence Hotline, in partnership with the National Center on Domestic Violence, Trauma & Mental Health, found disturbingly high rates of abuse specifically targeting survivors' mental health or use of substances. Although survivors have reported these tactics for decades, these surveys provided the first large scale, quantitative data on the issue, including that abusive partners intentionally undermine their partners' sanity or sobriety; control their medication; interfere with their treatment, sabotage their recovery; and discredit them with friends, family, helping professionals, and in the courts.<sup>8</sup> The Substance Use Coercion Study (N=3,248) found that:

- » 27% of participants had been **pressured or forced to use substances** by their abusive partners.
- » More than half of the 15% of callers who had recently tried to get help for their substance use reported that their **abusive partner tried to prevent or discourage them from getting help.**

- » More than one-third (37.5%) said that their abusive partners **threatened to report their substance use to authorities** to keep them from getting something that they wanted or needed such as a protection order or custody of their children.<sup>9</sup>
- » Nearly a quarter (24.4%) reported being **afraid to call the police** for help because their partner said they wouldn't be believed because they were using, or that they would be arrested for being under the influence.

These forms of abuse not only compromise survivors' ability to engage in substance use treatment but also make it harder for survivors to access DV services, maintain custody of their children, and access protection through law enforcement or the courts. Stigma associated with substance use and mental illness contributes to the effectiveness of these tactics and creates additional barriers for survivors and their children when they try to seek help.<sup>10</sup>

How does all this apply to the national opioid epidemic? While trauma, opioid use and DV are clearly intertwined, there has been little attention paid to the potential role of DV and substance use coercion in people's use of opioids and opioid-related deaths – issues that are critical to consider in the development of strategies to address the opioid epidemic. For example, women who have been diagnosed with opioid use disorder are more likely to have experienced DV, sexual violence, and childhood sexual abuse, are more likely to have been prescribed opioids for chronic pain, and are more likely to self-medicate to cope with trauma. Women are also physiologically more likely to become addicted in a shorter period of time and to experience more severe health consequences from substance use. These factors increase women's risk for addiction, medical complications, overdose, and death, all of which are likely to be amplified in the context of coercion and DV.<sup>11</sup> Lesbian, gay, bisexual and transgender survivors



are also at greater risk for opioid use and addiction.<sup>12</sup> Yet, culturally humble/relevant, gender affirming, DV-specific interventions are rarely incorporated into substance use treatment or factored into opioid prevention and intervention policies.

These issues are particularly salient in situations where women's use of substances is met with more punitive responses. For example, use of opioids during pregnancy and increasing rates of neonatal opioid withdrawal syndrome (NOWS), have become major public policy concerns. Medication assisted treatment (MAT),<sup>13</sup> not opioid withdrawal – is associated with the best outcomes for women and their newborns,<sup>14,15</sup> yet any kind of opioid use during pregnancy is still considered child abuse in 23 states plus Washington, DC. Twenty-four states plus DC require health care professionals to report suspected prenatal drug use. In some states, illicit drug use during pregnancy is a prosecutable offense.<sup>16</sup> These stigmatizing and criminalizing policies continue to be promoted despite clear evidence demonstrating that



supporting mother-infant bonding and attachment shortens the course of NOWS and improves infant wellbeing.<sup>17</sup> Considering the role that substance use coercion may be playing in survivor's risk for involvement in the child protective services and criminal justice systems (including being coerced into illegal, activities, unwanted sex, or trafficking under the threat of forced withdrawal) is critical to the development of DV-informed state and federal opioid policy, as well.

Access to treatment and services is also a key area of concern for DV survivors and programs and another important advocacy arena. While increased funding related to the opioid epidemic includes expansion of training, services, and naloxone distribution, access to treatment is still very limited.<sup>18</sup> For the DV field, this means creating partnerships between local, state, Tribal, and federal DV and substance use

providers and policymakers to address the lack of access to specialty substance use disorder treatment, including medication in many areas of the country and the even greater lack of access to comprehensive two-generation substance use services that are culturally relevant, gender responsive, LGBTQ2SIA<sup>i</sup> affirming, and trauma-informed. It also means addressing the current racial, class, and geographic disparities in treatment access (i.e., clinical vs. criminal justice responses, methadone vs. buprenorphine/naloxone; medication-only versus comprehensive wrap-around services) as well as the importance of increasing access to comprehensive pain management services. DV advocates can also partner with policy makers to expand the use of harm reduction strategies, including distribution of naloxone by DV programs and health care providers.

<sup>i</sup> Lesbian, Gay, Bisexual, Trans, Queer, Two-Spirit, Intersex, Asexual

## RESOURCES FROM THE NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH (NCDVTMH)

Mental Health and Substance Use Coercion Survey Report: <http://www.nationalcenterdvtraumamh.org/publications-products/mental-healthand-substance-use-coercion-surveys-report/>

Substance Use/Abuse in the Context of Domestic Violence, Sexual Assault, and Trauma: <http://www.nationalcenterdvtraumamh.org/publicationsproducts/substance-useabuse-in-the-context-of-domestic-violence-sexual-assault-and-trauma/>

The Relationship Between IPV and Substance Use: Applied Research Review: <http://www.nationalcenterdvtraumamh.org/wpcontent/uploads/2014/09/IPV-SAB-Final202.29.1620NO20LOGO-1.pdf>

Fact Sheet: The Relationship Between Intimate Partner Violence and Substance Use: <http://www.nationalcenterdvtraumamh.org/2016/09/newresource-fact-sheet-the-relationship-between-intimate-partner-violence-and-substance-use/>

Real Tools: Responding to Multi-Abuse Trauma: [http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/09/RealTools\\_RespondingtoMultiAbuseTrauma\\_BlandandEdmund.pdf](http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/09/RealTools_RespondingtoMultiAbuseTrauma_BlandandEdmund.pdf)

Mental Health and Substance Use Coercion Toolkit: <http://www.nationalcenterdvtraumamh.org/publications-products/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence-a->



“Dezire” by Sakhal Star, 2012  
AddictionandArt.org

It is critical that federal, state, and local agencies responding to the opioid epidemic incorporate strategies that specifically address the interplay between DV, coercion, trauma, and substance use. **Incorporating information about both DV and about substance use coercion into training programs for substance use disorder treatment/peer recovery support providers, introducing evidence supporting the effectiveness of harm reduction that addresses DV, and developing trauma-informed, culture and gender-responsive policies and practice standards are key priorities.** Strengthening collaboration between harm reduction, substance use treatment providers, and DV programs at the state and local level can also play a critical role in moving toward more effective intervention and prevention. The articles featured in this e-Bulletin offer an array of approaches to addressing the needs of people whose lives are impacted by substance use, opioids, trauma and DV – approaches that share a profound respect for the dignity and humanity of people who are dealing with these complex and intersecting concerns and that we hope will inform policy and practice moving forward.

1. Phillips H. Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL 2014 [http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet\\_IPVTraumaMHChronicIllness\\_2014\\_Final.pdf](http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf)
2. Dillon G, Hussain R, Loxton D, Rahman S. Mental and physical health and intimate partner violence against women: A review of the literature. *International Journal of Family Medicine*. 2013;313909.
3. Devries KM, Mak JY, Bacchus LJ, Child J C, Falder G, et al. Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLoS Medicine*, 2013. 10(5).
4. Nathanson AM, Shorey RC, Tirone V, Rhatigan DL. The Prevalence of Mental Health Disorders in a Community Sample of Female Victims of Intimate Partner Violence. *Partner Abuse*. 2012; 3(1):59-75
5. Trevillion K, Oram S, Feder G, Howard LM. Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. *PLoS One*. 2012;7(12)
6. 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.
7. Warshaw C, Lyon E, Phillips H, Bland P, Hooper M. (2014). Mental Health and Substance Use Coercion Survey: Report on Findings from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline (<http://www.nationalcenterdvtraumamh.org/publications-products/mental-health-and-substance-use-coercion-surveys-report/>).
8. Ibid. Warshaw C., et al. 2018
9. Ibid. Warshaw C., et al. 2018
10. Warshaw C, Tinnon E. Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. 2018
11. Opioid Use, Misuse and Overdose in Women (2016). US Department of Health and Human Services, Office on Women's Health, Washington, DC.
12. Girouard MP. Addressing Opioid Use Disorder Among LGBTQ populations. Fenway Institute and the National LGBT Health Education Center, Boston, MA. 2018
13. "Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, including long acting opioids, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders." SAMHSA <https://www.samhsa.gov/medication-assisted-treatment>
14. Substance Abuse and Mental Health Services Administration: Clinical Guidance for Treating Pregnant and Parent Women with Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.
15. Patrick SW, Schiff DM. AAP Committee on Substance Use and Prevention: A Public Health Response to Opioid Use in Pregnancy. *Pediatrics*. 2017;139(3):e20164070
16. States' Policies on Substance Use During Pregnancy. <https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy>
17. Ibid. SAMHSA, 2018
18. Substance Abuse and Mental Health Services Administration, 2018. Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/dat>

# COMMITTED TO FIGURING IT OUT: MEETING SURVIVORS WHERE THEY ARE AT IN OHIO

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Domestic violence (DV) programs are proud of our decades-long history of acknowledging and coming up with solutions and creative approaches to address the challenges and barriers caused by or related to DV that impact survivors' complicated lives. In Ohio, as in many places across the country, the opioid epidemic has had a devastating and far reaching impact—on families, workplaces and businesses, first responders and health care systems, on child welfare organizations, and of course, on domestic violence programs. DV programs are used to having a lot thrown at them—but how to work with those addicted to opioids in residential programs is particularly daunting. We had our work cut out for us as we knew we needed to come up with strategies.

## **How did the Ohio Domestic Violence Network (ODVN) get involved in all of this?**

ODVN's movement into addressing the opioid crisis in

DV programs came from a project that technically had nothing to do with substance use. ODVN had been awarded a federal three year demonstration grant to develop best practices for DV programs on addressing mental health challenges and head injuries in service provision. Yet as often is true in DV advocacy, beneath the surface, brain injury, mental health, substance use and the opioid epidemic became clearly interrelated and connected.

ODVN began our brain injury and mental health project by following DV advocacy best practices: we went to the programs who were a part of the project and asked them about their experiences, what support and assistance they needed from ODVN, and then shut our mouths and listened to their answers. Even though our conversations with program staff did not include one question about substance use or abuse, all 11 of the focus groups of advocates we listened to brought up their challenges, struggles and desperate

need for guidance on how to address opioid use in residential program settings. Programs had experienced overdose deaths, struggled with how to serve and house survivors actively addicted and those in recovery, and wondered how to best address the needs of the children residing in shelter. What needed to happen to make the shelter environment a healing, welcoming place for all people? We at the statewide coalition had no easy answers—turns out no one in the country has figured this out yet—but we decided to partner with our programs and move forward on developing guidance on strategies to best address these interconnected issues.

### Do they have grants for this?

As we were digging through our data on brain injury and mental health, our research partners at The Ohio State University (OSU) received an announcement that OSU had developed a new fund called the Opioid Innovation Fund, to devise new evidence-based approaches that could be implemented at scale in Ohio and across the nation. Of 89 initial pre-applications, OSU and ODVN's application was selected as one of eight inaugural planning research grants called "Building Recommended Practices for Working With Survivors of Domestic Violence Using Opioids in Residential Services: A Community Engagement Approach." The project's goals are threefold:

- » Obtain in-depth information on the challenges DV residential programs face when working with survivors using opioids, and what type of support agencies need to better address opioid use,
- » Examine prevalence of opioid use and overdose experiences of DV survivors accessing residential services,
- » Explore any regional differences across Ohio, including differences in urban and rural areas.

The project will be overseen by the Opiate Response Guidance team, which is made up of staff at ODVN, research partners at OSU, and most importantly representatives from five DV shelters across the state.

### So how are we going to go about tackling this?

We went back to the tried and true foundational principles of survivor defined DV advocacy again for this project. They guided our process from the beginning and we committed to being fully inclusive by inviting all residential DV programs across the state; by forming a true partnership between ODVN and DV programs, by starting where the survivor is by listening more than we talk and by creating a non-judgmental space where people can share freely what programs are experiencing. As a result, "ODVN can better understand program perspectives on what the challenges are and opportunities are, what has worked well and how to increase the safety and well-being of all survivors and staff at DV programs."

On June 5, 2018, ODVN gathered programs at *The Summit: Opiates and Domestic Violence Shelters*, which was held in Columbus, Ohio. Over 60 domestic violence program staff from 40 programs attended the day-long event, which was centered around three hour focus groups made up of DV program staff. Staff discussed substance use and abuse practices, overall thoughts and experiences of working with clients who used opioids in shelter, the impact of opiate use on shelter services and the larger community, concerns about addressing opiate use, current policies and procedures, and experiences with overdoses and naloxone.

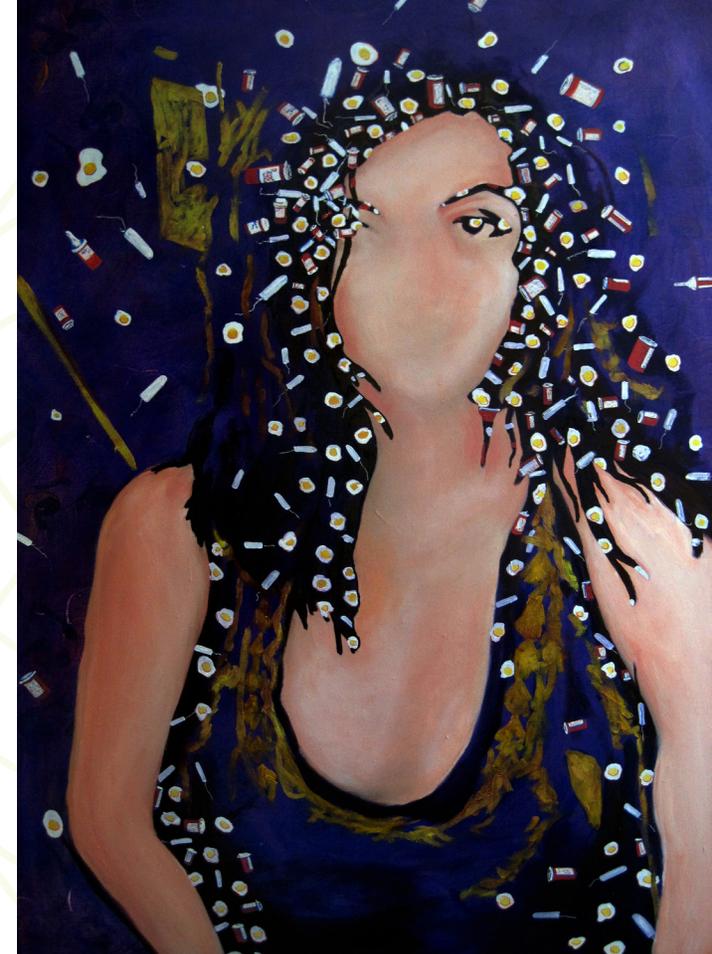
*"What needed to happen to make the shelter environment a healing, welcoming place for all people?"*

The Summit was an amazing opportunity for programs to be able to connect and many of the agencies that attended reported that it was really valuable to have time to talk with their peers about their struggles. DV shelter staff felt validated that they weren't alone in their experiences. Programs appreciated having ODVN intentionally include them in the process from the very beginning, by asking for their input—and that their input was respected, taken seriously, and will be used to shape the next phase of the project.

As this is a part of a research project, the Institutional Review Board-approved research team at OSU is currently in the process of analyzing the information generated from the focus groups at the Summit.

The analysis of the data will be brought back to the Opioid Guidance Response team to inform future program planning and the development of recommended practices related to opiate use in DV programs.

The second phase of the project will include anonymous phone interviews with survivors from 10 randomly chosen DV programs. Information collected will be informed by results from the Summit, but will include history of personal opioid use and barriers to substance use treatment. This phase of the project is currently in development and interviews are expected to begin in late fall of 2018.



"Where's Carmen" by Robyn Alatorre, 2012  
AddictionandArt.org

# Looking for more resources on supporting survivors who use drugs this Domestic Violence Awareness Month?

## NCDVTMH'S SUBSTANCE USE/ABUSE IN THE CONTEXT OF DOMESTIC VIOLENCE, SEXUAL ASSAULT, AND TRAUMA

[http://nationalcenterdvtraumamh.org/wp-content/uploads/2015/10/NCDVTMH\\_PatriciaBland\\_DebiEdmund\\_SubstanceUseDVSATraumaCurriculum.pdf](http://nationalcenterdvtraumamh.org/wp-content/uploads/2015/10/NCDVTMH_PatriciaBland_DebiEdmund_SubstanceUseDVSATraumaCurriculum.pdf)

A comprehensive curriculum and training module designed for advocates and their community partners to provide trauma-informed training on substance use and abuse in the context of domestic violence and sexual assault.

## SAMHSA OPIOID OVERDOSE PREVENTION TOOLKIT

<https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742>

This toolkit offers strategies for health care providers, communities, and local governments to develop practices and policies to help prevent opioid-related overdoses and deaths. Access reports for community members, prescribers, patients and families, and those recovering from opioid overdose. And more from the SAMHSA Center for the Application of Prevention Technologies: <https://www.samhsa.gov/capt/>

## HARM REDUCTION COALITION

<https://harmreduction.org/our-resources/>

A national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use.

## Webinars:

### NCDVTMH'S TRAUMA, OPIOIDS, AND DOMESTIC VIOLENCE WEBINAR SERIES

<http://www.nationalcenterdvtraumamh.org/trainingta/webinars-seminars/2018-trauma-opioids-and-domestic-violence/>

This webinar series examines the intersections between trauma, domestic violence, and the opioid epidemic; discusses innovative approaches to addressing these complex issues; and offer practical strategies for domestic violence programs and opioid/substance abuse treatment providers.

### NATIONAL INDIGENOUS WOMEN'S RESOURCE CENTER WEBINAR: FRAMING THE ISSUES: LOOKING AT THE OPIOID EPIDEMIC IN THE CONTEXT OF TRAUMA AND DOMESTIC VIOLENCE

<https://www.niwrc.org/resources/framing-issues-looking-opioid-epidemic-context-trauma-and-domestic-violence>

Provides an overview of what is known about the opioid epidemic and will focus on the specific concerns of Indian communities and tribal domestic violence programs and shelters.

### FUTURES WITHOUT VIOLENCE WEBINAR ON IPV/HUMAN TRAFFICKING AND SUBSTANCE ABUSE AND TREATMENT, WITH A LENS ON BEHAVIORAL HEALTH, SUBSTANCE ABUSE PROGRAMS AND DV AGENCIES

<https://www.futureswithoutviolence.org/ipvhuman-trafficking-substance-abuse-treatment-lens-behavioral-health-substance-abuse-programs-dv-agencies/>

# INTERVIEW WITH A HARM REDUCTIONIST



*Haven Wheelock is the Risk Education Specialist at Portland, Oregon's Outside In, a nonprofit nationally known for providing social and medical services to homeless youth and drug users, where Haven works to support the wellbeing of and advocate for drug users.*

*Kate: It is so great to get to talk with you, Haven. Tell me more about your work at Outside In.*

Haven: I coordinate HIV and hepatitis testing, naloxone distribution, fentanyl testing and the syringe exchange, at Outside In where we provide social and health services to homeless youth and people who use drugs.

*K: Advocates in the domestic/sexual violence field or movement have always been working to support all of the different issues that survivors are grappling with. Many are finding that they are needing new approaches, tools, resources, knowledge and partnerships to be able to support survivors who use drugs.*

H: Yes. I think programs and agencies of all kinds are rethinking how shelters, for example, are set up and how shelter rules that were put in place for safety reasons end up being huge barriers for survivors who use drugs.

*K: What are some of the common experiences that you hear about from your clients who are survivors of violence?*

H: Many of the folks I work with are survivors of violence. It is so common, especially for folks who live outside. They also have mental health issues, traumatic brain injuries, and just have a lot going on. For folks who are using, experiences of trauma and violence are another extra layer of complexity. As much as we want to say "just stop using drugs" there is so much power tied up into this situation. It can be hard because a woman can be in a situation with an abusive partner, and the partner not only is how she has housing, but they are also her only supply of drugs. Wielding access to drugs is such a powerful thing to control. With the fear and trauma that comes inherently with being a survivor, your ability to cope is...I believe addiction is a disease of despair and that

## Hearing from:

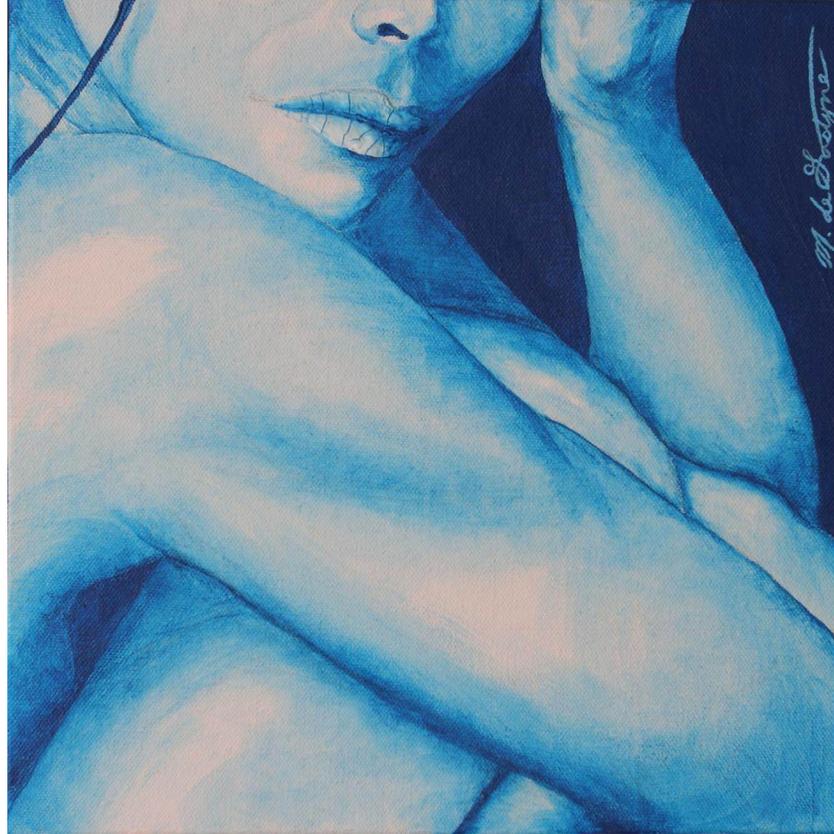
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using drugs is a coping mechanism. For many if you don't have other resources, tools and skills – using drugs is an effective way to get out of your brain. For some people it is their only means of survival. I think often service providers forget how important and valuable drug use can be for people. Yes, it makes life more complicated and hard, but it is something that people do for a reason. It is not completely irrational that people are using drugs. While you're dealing with traumatic things, drug use may be the only means of coping. Beyond that you have situations where there are power dynamics and abuse...partners are using together... I think all people have a certain level of basic needs that they need to survive every day. And when you're in active drug addiction, one of those things will always be drugs. You can't survive without them. So people will do all kinds of things in order to make sure they have it. They may sacrifice so much, including their own safety, or what we as service providers perceive as safety. So it can be so much harder for folks who are actively using or in addiction. So many of the services that are available are restrictive and in their own way, not safe, for drug users. People who are active in meth use aren't the pretty shelter candidate.

*K: What are some other barriers that drug users who are surviving abusive relationships might experience when trying to seek services?*

H: There are so many barriers to care for people who use drugs and people who are surviving abuse. Stigmatization of drug use is very real in people's lives. Another thing to think about, in a lot of places, the drug



**"Open" by Monica de Gastyne, 2012. AddictionandArt.org**

using community is very tight knit – a beautiful community of people who are really interconnected and interdependent because they have to be. This could add an additional layer for survivors who are in this community. It could be much less accessible to them if their abusive partner is also a part of the same community. But I have also seen the community be a huge source of support for people. Especially when other options – like going to the police – are actually not an option. I have only seen one person – in my 15 years of doing this work – that got law enforcement involved, and that was only after her abusive partner had stabbed her. The threat of being criminalized for using what

mechanisms you have to survive is real and you do not want to be labeled in the community as someone who talks to the police. So when an agency says "You should get law enforcement involved," it means that that agency is no longer safe.

Some survivors feel like, "Why would I call a shelter program? I am currently sleeping in my car. They do not think of me as someone who is in a dangerous situation. They think I am only saying it's abuse in order to get into a shelter." This is something we hear a lot. But there are also a lot of agencies out there who are trying to do the right thing.

*K: That brings me to my next questions...how can DV/SA advocates work to support survivors who use drugs?*

H: Oh my goodness...DV agencies could even just have sharps

containers at the DV drop-in centers or shelters. Having sharps containers in your bathrooms does not mean people use them more or less, it just means that they will feel more welcome and respected. DV agencies could have lower barrier shelter policies. They could be trained in using naloxone. They could open a syringe exchange program!

*K: What about in the community more broadly?*

H: Advocates' voices are going to be important in advocating for safe consumption spaces and other harm reduction services. Advocates are able to articulate, why, for example, it could be important for there to be separate consumption spaces and needle exchanges for everyone who does not identify as a cis-male – they just opened one in Vancouver, BC! Drug services in general have a lot to learn from advocates about being trauma and healing centered. That is a lens that you all definitely bring to the table.

*K: Can you talk more about the opportunity of partnering with each other?*

H: Yes! We have gotten amazing work done with the people working on DV in Portland, OR – we partnered with Call To Safety, the women's crisis line here, and the county health department to put together the bad date line! I always worry about giving referrals...I need to know that my clients are going to be treated with dignity and respect, so it has been

so important for us to have each other as trusted allies. I know that my clients can call and aren't going to be met with "you're too high to talk to me right now, call back later."

*K: What are some first steps in partnership building?*

H: Meet with people doing the work – have coffee! Talk about shared experiences! You know...if I were running a ladies-only syringe exchange night, I would LOVE to have an advocate there. Someone there who is not afraid of drug users and creates the space where it is okay to talk about what is going on in their relationships. It could be safer, and much lower barrier, to get those services at drop-in syringe exchange than going to a drop-in DV center.

*K: It seems like there is a lot of overlap between harm reduction and safety planning.*

H: There is always so much overlap in the work we do. Safety planning is harm reduction. We are working with humans. Why do we silo social justice movements? We forget that that is not how our people navigate the world. At the end of the day, we are all doing harm reduction to help people live the lives they want and deserve to live. Reducing harms of drug use, trauma, violence...things that are not separate in people's lives.





## Online Resources from the National Health Resource Center on Domestic Violence

### relationships can affect health

learn how you can support intimate partner violence survivor wellness and promote healthy relationships

### ipvhealth.org

Everything you need to address domestic violence and sexual assault in *all health settings* and promote survivor health and wellness at domestic violence advocacy agencies.

### ipvhealthpartners.org

A step-by-step toolkit developed for and by *community health centers, in partnerships with DV programs*, aimed at establishing and expanding partnerships between health centers and domestic violence advocacy agencies.

#### get access to:

- advocate specific tools
- sample model policies
- training and quality improvement tools
- reimbursement strategies
- multi-lingual and cross-cultural patient and provider tools
- and much more!

# CHANGING LANDSCAPE: 30 YEARS AT THE INTERSECTION OF HEALING, ACCOUNTABILITY, AND ADDICTION



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Southeastern Pennsylvania is being hit hard by the wave of opioid abuse. This year, Philadelphia, where I help to direct an intervention program, Menergy, for people who have harmed their intimate partners, has the unfortunate distinction of topping the list for worst opioid death rate among major U.S. cities. Billboards have sprung up in neighborhoods urging residents to “save a life” by carrying naloxone.

Addressing opioids as a public health crisis is the right approach. And contrasting this response to previous responses to past drug crises—that were identified with poorer communities—can potentially be useful as we think about our efforts to address domestic abuse.

Substance abuse has long been a complicating factor woven through domestic abuse intervention work. Menergy began in 1984 at the height of the crack epidemic. As a young counselor in our program 20 years ago—at a time when methamphetamine use was at its height—I interviewed men who described memories of childhood in the 60s and 70s with older neighbors sitting on stoops in front of their houses, always ready to call their parents if they saw them misbehave. But then in the 80s, as crack cocaine flooded the streets and young people were enlisted in its delivery and sale, many of those older people no longer felt safe and shuttered themselves away inside—leaving the young folk with no supervision, and the streets less safe.

*“In contrast to the current save a life billboards, “wars” on previous drugs imposed disproportionately long prison terms on people of color in poor communities.”*



In contrast to the current save a life billboards, “wars” on previous drugs imposed disproportionately long prison terms on people of color in poor communities. In a big urban center like Philadelphia, this resulted in the removal of large numbers of parents from the lives of children, a good number of whom have now grown into adults participating in our program.

There’s no question that some of those same structural inequities and biases play out in our safety and accountability efforts with domestic abuse offenders. In a relatively long-established program like Menergy, we see people whose routes to our program often get referred to as voluntary (from therapists, faith communities, HR departments, etc.) and involuntary (the courts, child welfare). Voluntary clients are disproportionately white and on the wealthier side. Meanwhile, our court systems routinely refer more poor people, and people of color. This is not because rich and/or white people are less abusive,

or because their abuse is less prone to breaking a law. Rather it’s because their resources allow them to access supports earlier and, as campaigns like Black Lives Matter have so vividly highlighted, because they are arrested less frequently and less violently for the same offenses. Even when arrested, our clients with more resources often escape more serious consequences because they can pay for better representation.

Recognizing and, to the extent we can, working to address structural inequity and bias in our accountability systems is one thing. Perhaps more complicated is identifying their impact internally in our intervention work. If we know that disciplinary procedures in schools, hiring practices in business, and the rental and real estate industries all have well-documented tendencies to privilege certain people and punish others, should we imagine that our intervention programs do not?

At Menergy we work to incorporate questions about privilege and discrimination into our conversations about the people we work with, and to push each other to be accountable for our own biases. We know we don’t always do this well.

My hope for our field is that as we continue to work toward increasing safety and healing in the lives of our intervention program participants and their families, and that we consider how our accountability efforts may be disproportionately punitive to some, while protecting others.

# INTERVIEW WITH AN ADVOCATE WHO IS DOING THE WORK



Hearing from:

**Stefani Keys**  
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Family Refuge Center  
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Interviewed by  
Kate Vander Tuig,  
Futures Without Violence

*Kate: Hello Stefani! Can you tell us a little bit about the work you do at Family Refuge Center in West Virginia?*

Stefani: I am the Shelter Manager at Family Refuge Center here in Lewisburg, West Virginia where we offer shelter and support services to survivors of domestic and sexual violence. I supervise our shelter staff, network with different community agencies, work on housing transition assistance, and facilitate weekly groups for survivors.

*K: Some DV programs are reluctant to offer shelter services to people who use drugs. Can you give us some examples of ways that your programs are accessible to people in your community who use drugs?*

S: We want to make sure that all survivors in our community have access to support. We are here to be a listening ear for people...we would never want someone coming here to feel judged by us or ashamed. There are many people living around Lewisburg and in West Virginia who use drugs. Many of the folks who come to us are using drugs as a way to cope with the hard stuff that is going on in their lives and past trauma. They are self-medicating.

*K: Your program is doing what many of us in the anti-violence movement would consider innovative work to meet the needs of survivors who use drugs. Can you talk a little bit about your personal and agency values that drive your advocacy efforts?*

S: People come to our programs with different needs, hopes, struggles, priorities and stories. We really want to meet everyone where they are at. I don't know that I would say what we are doing is innovative...if we did



not allow people who use drugs to come to shelter unless they were sober, there would be literally be no work for shelter advocates to do. If I were to say “You can come stay with us but you have to stop using drugs,” the person would just look at me and say “Alright, you’re crazy, I’m leaving.” If we required people to be in recovery or treatment before coming to shelter, then we would not be meeting their safety or crisis needs. We want to just make clear that we understand that they are a drug user and that they can continue to use while they are staying with us, but just not use drugs in the shelter. We ask folks to not use while physically inside of the shelter building because it goes back to the safety issue—there may be other people there who are in recovery, there may be kids, etc. We want to be that bridge that is getting people what they feel they need to live a safe and full life. Sometimes that means connecting survivors to addiction services or driving them to the methadone clinic, sometimes it doesn’t.

*K: Are these practices things that Family Refuge Center has always done, or did you have to make changes to your programs? How did that go?*

S: We have always worked to serve survivors who use drugs, and I think as the problem has changed in our community we have had to change with it in some ways. When I came on as Shelter Manager a few years ago, we did make some changes to our services. As we started looking at addiction in a different way, we have become more comfortable supporting folks who are struggling with this issue. I made sure that survivors who are users feel safe coming here, that we are not going to judge them, that they don’t feel afraid sharing their story with us. We are now able to offer people rides to methadone/suboxone treatment centers if they need it. We have the public health department come to train our staff on how to use naloxone. We listen to survivors and follow their lead. In a lot of ways, everyone’s stories are



different and people are needing different things from us. Family Refuge Center works really closely with the West Virginia Coalition Against Domestic Violence. They had a round table meeting for all of the DV programs working on this issue. After that meeting, it was unanimous: “we are going to support survivors who use drugs no matter what it takes”, “how can we share ideas and work together and learn from each other?”

*K: It sounds like you all are definitely committed to meeting the needs of your community. How do you support your staff to be able to address these issues or take care of themselves when difficult situations happen in shelter?*

S: I recognize that working with people who have a lot going on in their lives can be hard. I make sure that we take time as a staff to educate ourselves about addiction and drug use. We are constantly discussing how to best support the folks who are staying with us...we have a lot of the tough discussions.

We are very open here at Family Refuge Center and we all rely on each other for support. If one of us needs to take some time or take a break we step in for each other. I encourage all of my staff to take care of themselves and take breaks. There are times that we as staff need to check out for a little while or maybe a day. Self-care is not just a side thing, it is important.

*K: Tell us about any partnerships you have forged in order to better support people in your program who use drugs? Do you see an opportunity for advocates to partner with needle exchanges, harm reduction clinics, recovery/addiction services, or safe consumption spaces?*

**“We understand that many people who are using opioids are trying to deal with physical and emotional pain in the ways that are available to them”**

S: We do a lot of outreach with our community partners. There are various treatment programs in our area and neighboring states that we have partnered with and that we make referrals to. I do definitely see an opportunity for advocates to be partnering with needle exchanges, harm reduction/safe consumption programs. Every day, we are always trying to build a network of support for this. It is really about learning from each other and about figuring out how we can support each other. Right now, we don't have safe consumption spaces in West Virginia.

*K: There is a lot of focus right now on finding solutions to the opioid epidemic – in the news, in policy, etc. Many communities across the country have been hit hard by the effects of opioid addiction. What role do you see domestic and sexual violence advocates playing in this national conversation? Why are advocate voices important?*

S: Advocates look at this epidemic differently than other people do. We understand that many people who are using opioids are trying to deal with physical and emotional pain in the ways that are available to

them. We also see again and again how survivors who are using drugs are doing it because their abusive partner is making them use, or their abusive partner is using the survivor's addiction to hurt, control, or shame them. I rarely hear [this] addressed in the national conversation about opioids. On my drive to work this morning I was thinking about how some survivors who use drugs...sometimes that may be the one thing they do have control over in their lives – “when I want to do it, how much I want to do”, etc. It is a source of strength and control for them. We have to honor that they are meeting their own needs. This is an important perspective that we can share.

As advocates, we know to listen to the people who are most affected by the issue. They will tell us what they want from us. We can be a voice for them if they need it. We know not to try to tell people what to do, or control them...we know that we need to be meeting people where they are at.

*K: What advice would you give to DV advocates and DV advocacy organizations who are working to better meet the needs of survivors who use drugs or survivors who are struggling with addiction?*

S: I will be the first one to say that before I did a lot of my own research and education, I had a bad disposition about addiction. My advice is to be patient and educate yourself on drug use and addiction, attend different trainings. Knowledge is power and it can take away a lot of the fear that people may have around this. Why it happens to people, how people have to cope, and how they can be supported.

Advocates are always working to better meet the needs of all survivors and this issue is just another one that we have to be addressing and meeting head on right now. Addiction touches all of us and so does violence. You can be a beacon of hope and organizations can be an important bridge for people who are going through this.

# RESOURCES FROM THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

Check out our multilingual, low-literacy patient education safety cards that provide information on healthy and unhealthy relationships, their impact on health and list national referrals for support. The evidence-based safety card tool was developed to help clinicians and domestic violence/sexual assault (DV/SA) advocates have open conversations about DV/SA and healthy relationships with their clients. In partnership with health care providers, advocates and survivors, we have developed the following:

## Setting Specific and Topical

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- HIV Testing and Treatment
- Home Visitation
- Pediatrics
- Perinatal Health
- Primary Care/General Health
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- American Indian/Alaska Native
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- Hawaiian Communities
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To view and order visit  
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## THE HEALTH E-BULLETIN IS PRODUCED BY THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

### For free technical assistance and educational materials:

FuturesWithoutViolence.org/health

IPVhealth.org

M-F 9am-5pm 415-678-5500 TTY: (866) 678-8901

health@FuturesWithoutViolence.org



## ABOUT THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE:

For more than two decades, the National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. A project of Futures Without Violence, and funded by the Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services, the Center supports leaders in the field through groundbreaking model professional, education and response programs, cutting edge advocacy and sophisticated technical assistance. The Health Resource Center offers a wealth of free, culturally responsive materials that are appropriate for a wide variety of health professions and settings.