

3.4 Safety Planning with Women Using Substances

BY TESSA PARKES

3.4.1 Substance Use And Safety: Making More Connections

“Substance use and intimate partner violence are not linked in a linear manner, but interconnect in a web of social and structural issues” (Greaves et al 2006).

For many women experiencing violence, patterns of substance use are closely linked to the violence and abuse that they are experiencing. This link should not be understood as a causal relationship, “but [as] one where the practice issues of safety planning, and identifying the strategies of power and control, need to be addressed in the context of, and intersection with, problematic substance use” (The Stella Project 2005). In addition to this, and as described earlier in this tool kit, research has shown that as many as two-thirds of women with substance use problems may have a concurrent mental health problem such as depression, post-traumatic stress disorder, panic disorder or an eating disorder (Poole 2004). This means that many of the women you work with will be trying to cope and manage all three problems: violence, mental health problems and substance use. While the sections on safety planning for a woman with mental health problems and substance use problems have been written separately, there is obviously much overlap in the issues and in how they present for women in their lives. We hope you will start your safety planning process with a focus on violence, and then add on mental health and substance use issues when appropriate to do so.

“It is important for anti-violence services to work from the assumption that the women they serve will likely need to examine their current substance use in the safe context that an anti-violence service can provide. And the work that anti-violence services do with women on safety planning and identifying the workings of power and control needs to be informed by the realities of problem substance use” (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4 2007).

To undertake effective safety planning with women who use substances, we need to understand the context of their lives and the interconnectedness of violence and substance use. There are many interconnections, for example:

- Many substance-using women who are in violent relationships were introduced to drugs by their partners, who then use substances to gain and maintain power and control.
- Many women with substance use problems began by using substances that were prescribed by their physicians.
- Alcohol and drug use, by the perpetrator or the women herself, is associated with greater severity of injuries and increased lethality rates.

- For IV drug users there may be risks associated with their partner using the drug use to abuse them, by, for example:
 - forcibly establishing drug use in the context of a relationship
 - forcing women to trade sex for drugs
 - determining the woman's drug supply
 - shooting up for the woman
 - deliberately using dirty needles or cottons or missing a vein on purpose (Bland 2001)
- A woman may be dependent on her abuser for access to drugs and this may be a factor preventing her from leaving.
- The compulsion to drink or use may make it difficult to access services such as shelters, advocacy or other forms of help.
- Service providers may see women as having reduced credibility if they have substance use problems, which can reduce their access to community supports.
- The wider impact of a chaotic lifestyle may also create problems, with a woman having little control over who is around her and her environment in general.
- Women in violent relationships who have substance use problems often believe that their use of a substance means the violence against them is warranted.
- Active and regular substance use can make it harder to escape from a violent situation or to heal from past abuse.
- For a woman experiencing violence, substance use treatment may be seen as less urgent than getting safe.
- Women who use substances may be more reluctant to seek assistance or contact police for fear of arrest, deportation or child protection service involvement.
- A woman may fear that she will not be believed if she makes a complaint—this may have been borne out for her in prior experiences.
- If she is in recovery from using substances, she may fear relapse if she leaves to face an unknown future (Alaska Network on Domestic Violence and Sexual Assault 2005).

We have included a Power and Control Wheel for Women's Substance use (O'Neil 1996, adapted from the Domestic Violence Intervention Project, Duluth) in Appendix 21. This provides more detail on how substance use can be dynamic in violent relationships.

3.4.2 Risks To Safety

Because of this interrelatedness of violence and substance use, cessation of drinking and drug use alone cannot ensure safety. Indeed, recovery is often accompanied by more danger for women, as the violent partner finds that they are less able to control them than previously. They may seek to gain new ways of control and to sabotage recovery or treatment efforts. The exact risks will obviously vary for different women; for example, in rural contexts further isolation and disconnection from social and community supports may be particularly destructive, in addition to the lack of anonymity.

When under the influence of substances, a woman may be less able to accurately assess the level of danger posed by a perpetrator, and she may have impaired judgment and thought processes in a number of areas that make safety planning more difficult:

- She may think she has more power than she does and can defend herself against her partner during a physical assault.
- She may find it more difficult to make decisions that might protect her from the abuser.
- She may have a harder time recognizing options or gauging her safety if a situation escalates.

- She may have no memory or a distorted memory of violence that happened when she was under the influence; she may think she is able to handle it.
- She may fail to remember how an injury was sustained or fail to remember making a police report.
- She may find it more difficult to remember a safety plan.

Despite many of these difficulties we need to still see the woman survivor as the expert on her own and the abuser's behaviour and likely responses. We can combine her expertise with our professional wisdom and research evidence.

3.4.3 Conversations Aimed At Reducing Risk And Increasing Safety

"Critical to supporting women with substance use problems is reducing shame about having a problem, promoting understanding of substance use and its risks, as well as eliciting hope that change is possible" (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 3 2007).

Given the shame, guilt and other negative emotions connected with substance use for women it is vital that our conversations with them acknowledge these negative emotions and show our respect for them as women and for their struggles:

One of the most important interventions you can make is to have a conversation with a woman where her substance use is discussed, she is asked about how her use affects her and what she needs to stay as safe as possible. Crucially, we also need to ask how her or her partner's substance use is affecting the violence she is experiencing. A woman may find it easier to talk about her partner's use before she feels safe enough to talk about her own.

Questions to ask a woman who is using substances to help with safety planning include:

- Does your partner use your drinking or drug use to hurt you? If so, how?
- Has your partner used alcohol or drugs to control/threaten/shame you? If so, how?
- When you were not drinking or using drugs in the past, what helped you to cope? Can you do that now?
- Can you tell me why it may not be safe to use when someone is being violent towards you/stalking you?
- How can your drinking or drug use (together with your experience of violence/trauma) affect your parenting/housing/police response/legal response/interactions with MCFD, other systems or issues?

Recognizing that violence towards women can be connected to an increase in use or be a relapse issue (can make women turn back to using substances after having worked on quitting) is crucial (www.accessingsafety.org).

3.4.4 Strategies To Use To Increase Safety: The Value Of Harm Reduction

A harm reduction approach can be very helpful when discussing women's safety when she uses drugs or alcohol. A conversation focused on altering use provides more room to work together and provide support than a conversation promoting abstinence. For example, she could consider switching to safer drugs, reducing the number of drugs used, eating before drinking, etc.

Another approach would be to ask her questions about the context of her use and how this context creates additional vulnerability. Questions such as

- Where do you commonly use/drink?
- Who is around when you are using?
- What dangers do these people present to you?

Exploring together how a woman may keep herself safer in potentially unsafe contexts and around unsafe others may also be very helpful for her. You can help her to explore what choices she may have in exerting control in potentially risky situations. Questions that may be helpful here include:

- Are you able to use/drink with safer people?
- Are you able to drink/use in less risky places?
- What can you do when others'/partner's threatening or risky behaviour starts to escalate?
- Is there someone you trust whom you can call to come and help you if things start to escalate?

Some other areas you may want to consider are:

- Providing information—Provide information (in different formats) to women who use substances on their increased risks and ask for their collaboration in discussing ways of minimizing the risks associated with their substance use (see section on harm reduction approach for more ideas here).
- Risks from treatment—Substance use treatment can be risky for women in a number of ways:
 - They may encounter re-traumatizing practices as part of their treatment, such as feeling coerced into particular ways of stopping or reducing their use.
 - They may encounter approaches that add to their shame and guilt rather than offering them acceptance and hope.
 - They may not be able to access women-only services in their local area, which may make them vulnerable to being in physically unsafe or emotionally unsafe environments.
 - They may have to make a choice between staying with their children and getting treatment. This may be risky in a number of ways, particularly if the woman fears for her children's safety or fears that she will lose custody if she places herself into treatment.
 - sWhere possible, try to help a woman to access treatment settings that are sensitive to the needs of women in violent relationships. This is not always possible, particularly in rural and isolated areas. If not possible, try to maintain contact with a woman while she is in treatment to continue your support.

Sometimes new risks are presented when women access substance use treatment. For example, women who access methadone programs may be tracked by abusers because of the need to appear daily at a set time for their prescription. This and other individual risks need to be considered when drawing up a safety plan.

- Attend to the substance use directly— If a woman has indicated that she wants to stop her substance use, then you could create a substance use recovery plan to work alongside the safety plan. This acknowledges that the two issues are profoundly related. If she does not want to make abstinence-

focused changes, then a substance use harm reduction plan can be discussed along with her safety plan (see *Moving Towards Safety: Using a Harm Reduction Framework*). Ideally, a referral to a woman-centred substance use/addiction service would occur when a woman is ready to quit or substantially alter her use. With her consent, it would be important to share her safety plan with her addiction worker, so that the recovery plan they create complements and supports her safety plan. Checking in with her on her recovery efforts and evaluating any impacts on her safety remains part of the anti-violence work.

- Referrals and support from other agencies—Where at all possible, try to partner with appropriate woman-centered substance use services to facilitate referrals and coordination.

Good Practice Example

"At the Jean Tweed Centre, a women's addictions treatment centre in Toronto, counsellors have identified the parallels between supporting women in developing violence/trauma safety plans and relapse or risk reduction plans regarding substance use. Helping women make the connections between their safety planning, growth and change in both areas can be facilitated by both violence and substance use counsellors" (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4, 2007).

- Peer and mutual support— Find out if there are any integrated support groups (for substance use and violence against women) in your area, and if not, think of helping women start one. It can also be helpful to have copies of "A woman's way through the 12 Steps" by Stephanie Covington available in your services to help women get what they want from traditional support groups. (Dr Covington's website is <http://www.stephaniecovington.com/> and to order the book go to <http://www.amazon.ca/exec/obidos/ASIN/0894869930>.)

Alternative Support Groups

There are alternatives to the 12-step groups that provide options for those who do not feel comfortable with this approach. They are not as commonly available as 12-step groups but they tend to also have websites and online meetings as well as meetings in larger cities. The 16 Steps of Discovery and Empowerment group, developed by Charlotte Kasl, interprets the 12 steps in alternative ways that are more suited to women and other marginalized groups of people. The groups are based on approaches in her books *Yes You Can!* and *Many Roads: One Journey: Moving Beyond the 12 Steps*. Her version of the steps encourages those that attend to examine beliefs, addictions and dependent behaviour in the context of living in a hierarchical and patriarchal culture. See www.charlottekasl.com and use the email address at the website for information on online support groups.

Good Practice Example

Victoria Women's Sexual Assault Centre (VWSAC) identified the need to provide more in-depth support for women experiencing Post Traumatic Stress Disorder and substance use problems. They observed that women with trauma-related, mental health and substance use problems are often in crisis and rotate through services trying to get their needs met. VWSAC fostered a community collaboration that provides an integrated treatment model utilizing the *Seeking Safety* group model (Najavits 2002) as its foundation.

The programming consists of two connected yet stand-alone groups:

- *Seeking Information* (three or four weeks) explores the links between trauma and substance use. This group provides women with basic information and skills before making the commitment to a 12-week group;
- *Seeking Understanding* (11 or 12 weeks) examines specific topics related to trauma and substance use in more depth.

The groups are co-facilitated by a trauma counsellor and a drug and alcohol counsellor. Group goals include:

- Building awareness of the effects of trauma and substance use, the connection between the effects of trauma and substance use, and new ways of coping without substance use;
- Learning about new skills and having an opportunity to practice. Skills include things like problem solving, safety planning, asking for help, taking care of yourself, and harm reduction or abstinence;
- Increasing positive beliefs: decreasing shame and isolation and increasing self-esteem, self-acceptance, personal power, trust in self and others, self-awareness, hope (change is possible), compassion for self, and internal and external resources. (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4, 2007)

Their materials on working with women to assess potential risks, dangers, triggers and potential relapse situations, and to build internal safety, are excellent resources. Resources are given to women that help to develop self-caring and self-soothing skills and routines and containment strategies and to build the ability to tolerate painful feelings (see Appendices 14–20 for the resources we have been given kind permission to reproduce in this toolkit). Two additional resources from the VWSAC are *What inspires my healing?* (Appendix 22) and *How substance use prevents healing from PTSD* (Appendix 23). These are excellent resources to consider sharing with women.

Substance use may reduce a woman's
ability to gauge her level of risk

3.4.5 Additions To Safety Plans

When we are helping a woman with her substance use we need to remember that she may not have the autonomy or safety to be able to reduce her use without negative repercussions from an abusive partner.

In the context of drug or alcohol use, a woman may need to make specific safety plans or have additional aspects to her plan. Violence against women, drug overdoses and withdrawal from substances can all be lethal, so it is vitally important that the risk from each is assessed as well as the risk of a woman harming herself deliberately. These assessments should be reviewed regularly because of possible frequent changes in a woman's situation and emotional wellbeing. The Alaska Network on Domestic Violence and Sexual Assault has a resource kit called *Getting Safe and Sober: Real Tools You Can Use* on their website www.accessingsafety.org. The following suggested additions to a woman's safety plan have been taken and adapted from their tool kit and other online resources. This is an abstinence oriented safety plan and will not be appropriate for all women.

Mini Safety/Sobriety Plan at a Glance

- **Strategize** – Steps to reduce risk/use
- **Develop** – Options to keep safe/sober
- **Identify** – Trusted allies/safe sponsors
- **Plan** – Means to escape abuser/drugs
- **Discuss** – Referral resources
- **Avoid** – Danger/persons/places/things
- **Tools** – HALT/one day at a time.

This last point encourages a woman to recognize vulnerability cues such as HALT (be aware when you are hungry, angry, lonely or tired) and take one day at a time in moving towards safety and recovery. Understanding and planning for the physical/emotional/cognitive/environmental triggers and other cues indicative of risk is very important (see Appendices 13-17).

The following script could be added into and amended for use in a woman's safety plan where appropriate:

If drug or alcohol use occurs alongside violence in my relationship with my partner, I can enhance my safety by some or all of the following:

I will try to remember that:

- It is easier to keep safe when I am not using substances¹
- Alcohol and drug use can impair my judgment and make it harder for me to choose safe options and access services
- I find it hard to ask for help when I am using or drinking.

¹ This is generally the case, but some women may be safer when they are using with their abusive partner.

Things I can do:

- I can call _____ for support when I feel like drinking or using to cope.
- The following people/places/things can be unsafe for me

- My warning signs that I am getting stressed and craving substances are

- and this is what I will do in these situations to try to keep myself from drinking/using and to try to keep myself safe

- If I am going to use, I can do so in a safe place and with people who understand the risks of violence and are committed to my safety. I can

- I can also

- If my partner is using/drinking I can

- I might also

- To safeguard my children I might

- Other things I can do to help me feel stronger are

(Alaska Network on Domestic Violence and Sexual Assault 2005)

This script has also been placed in Appendix 24 as a handout.

3.4.6 Knowing When To Act Quickly: Managing Withdrawal And Overdoses

It is important to be aware of indicators of withdrawal or overdose in case you need to act quickly to get medical help. Drug emergencies are not always easy to identify. If you suspect a woman has overdosed, or if you suspect she is experiencing withdrawal, give first aid and seek medical assistance.

Effects of Different Drugs

- An overdose of narcotics can cause sleepiness and even unconsciousness.
- Uppers (stimulants) produce excitement, increased rate of heartbeat, and rapid breathing. Downers (depressants) do just the opposite.
- Mind-altering drugs (hallucinogens), including LSD and other street drugs, may produce paranoia, hallucinations, aggressive behaviour or extreme social withdrawal.
- Cannabis-containing drugs, such as marijuana, may produce euphoria, relaxation, impaired motor skills, and increased appetite.
- Legal prescription drugs are sometimes taken in overdose to achieve effects other than the therapeutic effects for which they were intended. This may lead to exaggeration of their effect (as can happen with uppers and downers), or serious side effects. (Adapted from www.helpguide.org.)

Drug overdose symptoms vary widely depending on the specific drug(s) used, but may include:

- Abnormal pupil size
 - Dilated pupils (enlarged)
 - Pinpoint pupils (very small)
 - Nonreactive pupils (pupils do not change size when exposed to light)
- Sweating
- Agitation
- Tremors
- Convulsions
- Staggering or unsteady gait (ataxia)
- Difficulty breathing
 - Shallow, decreased breathing (respiratory depression)
 - Labored breathing
 - Rapid breathing (tachypnea)
- Drowsiness
- Unconsciousness (coma)
- Hallucinations
- Delusional or paranoid behavior
- Violent or aggressive behavior
- Death

Drug withdrawal symptoms also vary widely depending on the specific drug(s) used, but may include:

- Abdominal cramping
- Agitation
- Cold sweat
- Convulsions
- Delusions
- Depression
- Diarrhea
- Hallucinations
- Nausea and vomiting
- Restlessness
- Shaking
- Death

Withdrawal from Benzodiazepines

Withdrawal symptoms can include insomnia, panic attacks, agitation, hallucinations, paranoia, depersonalization, derealization, depression, pressure in head, rebound anxiety, loss of appetite, weight loss, visual distortions, flashbacks, lack of concentration, agoraphobia, dizziness, sweating, nausea, nightmares, palpitations, creeping sensation in the skin, increased sensitivity to light, touch and smell, pins and needles, numbness and seizures and sometimes death (taken from www.benzo.org.uk).

Depressant Overdose Symptoms

- Moderate: uncontrollable nodding, inability to focus eyes, excessive drooling, pale skin colour, incoherent speech
- Serious: awake but unable to talk, body very limp, erratic or very shallow or slow breathing, excessive vomiting
- Severe: unconscious, blue skin, not breathing, can't find a pulse or pulse shallow and erratic, choking or gurgling sounds, lying in their vomit.

Stimulant Overdose Symptoms

- Moderate: incoherent speech, extreme paranoia, pale skin colour, jaw or teeth clenching, aggressiveness, minor shakes, excessive sweating, clammy skin, very rapid pulse
- Serious: inability to focus eyes, vomiting, foaming at the mouth, pressure or tightness of the chest, unable to talk, erratic pulse and violent actions
- Severe: seizures, unconsciousness, choking or gurgling sounds, not breathing, no pulse From www.heretohelp.bc.ca/publications/factsheets/crises_emergencies.shtml)

Alcohol Withdrawal Symptoms

Withdrawal symptoms often develop in three stages:

1. The initial phase, which begins within a few hours after drinking stops, includes tremulousness ("the shakes"), irritability, nausea and vomiting, and difficulty sleeping. These symptoms reach peak intensity within 24 to 48 hours, and subside in two or three days. Alcoholic hallucinosis— very real "bad dreams" or actually seeing or hearing things that are not there— can occur during this phase.
2. In the second phase, convulsions (seizures, "rum fits") can develop within 24 to 48 hours after stopping even heavier drinking. Convulsions have been reported to occur as long as five and up to 20 days later. Except in persons with epilepsy, the standard treatment of moderate to severe withdrawal described below is usually adequate.
3. Delirium tremens (DTs) is the third and most serious stage of alcohol withdrawal. They occur four or five days after prolonged, heavy drinking stops, at which time the person becomes severely agitated, extremely confused and disoriented, and has dilated pupils, fever, and a very rapid heart rate. Frightening hallucinations and bizarre delusions can also occur.

Reassurance and supportive nursing care in subdued surroundings are the basis for treating alcohol withdrawal states. Chlordiazepoxide (Librium), diazepam (Valium), and other benzodiazepines are the drugs most commonly used. Particularly with DTs, electrolyte imbalances should be corrected and adequate fluids administered; hallucinations should be treated cautiously. Thiamine (vitamin B1) is usually given orally or intramuscularly to most patients treated for significant alcohol withdrawal (taken from information at www.aadac.org).

Try to make sure that women are well informed about these indicators— share this information with them if appropriate.

Conclusion

■ ■ Safety includes knowing you are not being labelled or judged" (Alaska Network on Domestic Violence and Sexual Assault 2005).

As with the support of women with intersecting violence and mental health concerns, the issues for women with intersecting violence and substance use concerns are complex. Safety planning will need to take this into account and generate individualized plans that attend to the specifics of a woman's particular situation and that respond to changes in these situations. Allow plenty of time and patience for this process. Draw on harm reduction ideas to support your work with women, because this allows for much more creativity than simply taking an abstinence approach. Because these processes require honesty and trust to be effective, women require positive and non-judgmental supporters to help them with this challenging work. Ensure you can provide a woman with this in your working relationship and be prepared to meet her wherever she is at.

3.4.7 References, Resources And Further Reading

Accessing Safety Initiative: online at www.accessingsafety.org

Agar, S. 2003. *Safety Planning with Abused Partners: A review and annotated bibliography*. Vancouver: BC Institute Against Family Violence. Available at www.bcifv.org/pubs/SafetyPlanning_Agar.pdf.

Bland, P. J and Edmund, D. 2005. *Safe and Sober: Real Tools You Can Use: An advocacy and teaching kit for working with women coping with substance abuse and interpersonal violence*. Alaska Network on Domestic Violence and Sexual Assault. Available at www.accessingsafety.org.

Bland, P. 2001. Building a bridge from substance abuse to safety – for battered women. *The A-Files. Washington State Coalition Against Domestic Violence*. Vol 3. No 3. 128-135.

Covington, S. 1994. *A Woman's Way through the Twelve Steps*. Centre City, Minnesota: Hazelden Educational Materials.

Edmund, D. S. and Bland, P. J. 2006. Women talk about substance use and violence. *Accessing Safety Initiative*. Accessed at www.accessingsafety.org

Greaves, L., Chabot, C., Jategaonkar, N., Poole, N., and McCullough, L. 2006. Substance use among women in shelters for abused women and children: Programming opportunities. *Canadian Journal of Public Health*, 97, 5, 388-392.

Kasl, C. D. 1995. *Yes, You Can! A Guide to Empowerment Groups*. Lolo, MT: Many Roads, One Journey. See <http://www.charlottekasl.com/>.

McEvoy, M and Ziegler, M. 2006. *Best Practices Manual for Stopping the Violence Counselling Programs*. Vancouver: BCASVACP.

Najavits, L.M. 2002. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

Poole, N. 2004. Substance use by girls and women: Taking gender into account in prevention and treatment. *Visions: BC's Mental Health and Addictions Journal: Concurrent Disorders*. Vol 2. No. 1. 15.

Poole, N., and Coalescing on Women and Substance Use: Linking Research Practice and Policy Virtual Community. 2007. *Making Connections: Women's Experience of Violence and Substance Use Problems*. Sheet 1. Vancouver, BC: British Columbia Centre of Excellence for Women's Health, Canadian Women's Health Network, Canadian Centre on Substance Abuse. These information sheets can be accessed at the ActNow - Healthy Choices in Pregnancy website at www.hcip-bc.org.

Poole, N., and Coalescing on Women and Substance Use: Linking Research Practice and Policy Virtual Community. 2007. *Resolving differences in service philosophies*. Sheet 2. Vancouver, BC: British Columbia Centre of Excellence for Women's Health, Canadian Women's Health Network, Canadian Centre on Substance Abuse. These information sheets can be accessed at the ActNow - Healthy Choices in Pregnancy website at www.hcip-bc.org.

Poole, N., and Coalescing on Women and Substance Use: Linking Research Practice and Policy Virtual Community. 2007. *Discussing substance use with women and offering programming that addresses violence, substance use and related health and social issues*. Sheet 3. Vancouver, BC: British Columbia Centre of Excellence for Women's Health, Canadian Women's Health Network, Canadian Centre on Substance Abuse. These information sheets can be accessed at the ActNow - Healthy Choices in Pregnancy website at www.hcip-bc.org.

Poole, N., and Coalescing on Women and Substance Use: Linking Research Practice and Policy Virtual Community. 2007. *Information about substance use and addiction for women with violence concerns*. Sheet 4. Vancouver, BC: British Columbia Centre of Excellence for Women's Health, Canadian Women's Health Network, Canadian Centre on Substance Abuse. These information sheets can be accessed at the ActNow - Healthy Choices in Pregnancy website at www.hcip-bc.org.

Poole, N., and Coalescing on Women and Substance Use: Linking Research Practice and Policy Virtual Community. 2007. *Resources about women's experience of substance use and violence related concerns*. Sheet 5. Vancouver, BC: British Columbia Centre of Excellence for Women's Health, Canadian Women's Health Network, Canadian Centre on Substance Abuse. These information sheets can be accessed at the ActNow - Healthy Choices in Pregnancy website at www.hcip-bc.org.

Salmon, A. and T. McDiarmid (for Vancouver Native Health Society and Sheway). 2006. *Honoring Ourselves and Healing Our Pasts: Manual for Support Persons*. Vancouver: Vancouver Native Health Society.

The Stella Project. 2005. *Domestic violence and substance use: overlapping issues in separate services? Summary Report*. London Domestic Violence Project. Available at: http://www.gldvp.org.uk/C2B/document_tree/ViewACategory.asp?CategoryID=73.

