Recommendation Report: Developing Best Practices for Haven's Substance-Use Policy

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1. Introduction

The purpose of this report is to inform the development of Haven's new substance-use policy, which permits alcohol use as transitional housing is established on campus. It draws on research examining the intersections of domestic violence, trauma, and harm reduction practices, alongside participant interviews, to recommend policies, procedures, and programs for managing legal substance use on site. The goal is to establish best practices for harm reduction in shelter settings that uphold residents' safety, dignity, and autonomy.

Although Haven's new substance-use policy permits only the possession and consumption of alcohol, the research reviewed for this report considers harm reduction practices more broadly. This broader scope is intentional for three reasons. First, most existing studies address a range of substances, though alcohol is commonly included as the most frequently permitted. Second, examining harm reduction more broadly allows for a holistic understanding of the complex intersections between domestic violence and substance use, equipping staff with the empathy and preparedness needed to support survivors with diverse experiences. Third, policies are not static. By grounding this report in a broader framework, Haven gains a foundation to build upon should the scope of the policy expand in the years ahead.

Ultimately, the evidence demonstrates that harm reduction approaches can reduce stigma, encourage open dialogue, and strengthen survivor-centered care. Even as Haven's policy remains limited to alcohol, the principles outlined here highlight the importance of supporting residents who use other substances through informed referrals and nonjudgmental responses. In this way, Haven can balance safety with autonomy and ensure survivors feel both respected and supported as they navigate healing.

The sections that follow include: an overview of relevant research, findings from participant interviews, and a set of recommendations outlining short-term actions, long-term strategies, and clear guidelines for implementation.

2. Overview of Relevant Research

2.1. The Relationship between Domestic Violence and Substance Use

Developing a comprehensive understanding of the co-occurring experiences of domestic violence (DV) and substance use is foundational to enhancing support services for survivors. Research consistently shows that experiencing intimate partner violence (IPV) increases an individual's likelihood of substance use and its associated harmful consequences (Phillips et al., 2020a; Rivera et al., 2015; Macy & Goodbourn, 2012; Kilpatrick et al., 1997). The risk of developing substance use-related problems is further amplified by exposure to multiple forms of violence, abuse, or trauma over time (Phillips et al., 2020a). Survivors may use substances for various reasons: to cope with the trauma of abuse, as a form of self-medication, to manage low

self-esteem or loneliness, or as a manifestation of self-harm or self-destructive behavior (*The connection between sexual assault and substance abuse*, n.d.).

The occurrence of **substance use coercion**—in which an abusive partner uses a survivor's substance use as a tactic of power and control—further complicates the overlapping cycles of DV and substance use (Warshaw & Tinnon, 2018). Stigma surrounding substance use contributes to the success of these tactics, which may include pressuring a partner to use substances, preventing them from accessing treatment, sabotaging their recovery efforts, threatening to report them to authorities, or discrediting them in the eyes of service providers and support networks (Phillips et al., 2020a). As Gabriela Zapata-Alma, Director of Policy and Practice on domestic violence and substance use at the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH), explains:

> "'Interviews that we conducted in 2019 revealed that experiences of substance use coercion, substance use and domestic violence are incredibly pervasive and remain hidden or underreported because of stigma and the (often accurate) fear of not being able to access needed services and resources'" (Flannery, 2020).

Substance use coercion can have profound consequences for survivors and their children, particularly by limiting their ability to achieve economic self-sufficiency (Phillips et al., 2020b). For example, a survivor who has a criminal record resulting from coerced substance use may face additional barriers to securing employment, housing, or social service benefits. These challenges are compounded by the stigma surrounding substance use, which also creates obstacles to accessing DV and substance use treatment services (Phillips et al., 2020b).

Within DV programs, the most persistent barriers stem from a lack of awareness about how substance use, IPV, and substance use coercion intersect (Phillips et al., 2020b). Research identifies several systematic issues: sobriety requirements, limited staff training on how to support survivors who use substances, stigma among staff, and inadequate resources. In many cases, programs perceive survivors who use substances as requiring additional support that staff feel unequipped to provide (Phillips et al., 2020b). These barriers can also persist in residential settings, where strict rules and regulations may unintentionally mirror the power and control dynamics of an abusive relationship (Phillips et al., 2020b). These realities have significant implications for rethinking shelter policies related to substance use—particularly in ways that promote survivor autonomy, safety, and trauma-informed care.

2.2. Harm Reduction and Trauma-Informed Care

As a result of emerging research, many researchers, national agencies, community-based organizations, and service providers now advocate for harm reduction approaches within DV shelters and support centers. **Harm reduction** adopts a neutral stance regarding substance use in order to provide a range of service options that empower survivors to make choices aligned with their individual needs (Muth et al., 2024). Harm reduction does not require abstinence or treatment as goals; rather, it supports incremental healing and recovery based on the survivor's own priorities, which may or may not include abstinence (Vakharia & Little, 2017; Jean Tweed Centre, 2013). These models are increasingly seen as more effective than abstinence-only or

zero-tolerance policies, which have historically excluded survivors who use substances from accessing shelter services, ultimately placing them at greater risk of continued violence and instability (Muth et al., 2024). The integration of harm reduction approaches in DV programs and shelters helps providers to acknowledge the connection between IPV and substance use, having the potential to reduce survivors' vulnerability to violence while fostering self-determination and enhancing safety while using substances (Muth et al., 2024).

Hovey et al.'s (2019) study of substance use management practices in 46 DV shelters across Ontario, Canada, identified four key outcomes of harm reduction approaches: (1) improved accessibility by lowering barriers to shelter services, (2) increased openness and honesty around substance use, (3) advancement of a nonjudgmental environment, and (4) enhanced resident safety. Similarly, a U.S.-based study by Lee and Zerai (2010) found that participants felt less marginalized and more engaged in programming, reporting improvements in quality of life, social functioning, substance use patterns, and future goals. These findings reflect the foundational principles of **trauma-informed care**—a holistic approach that recognizes the widespread impact of trauma, prioritizes safety, trust, and choice, and seeks to avoid re-traumatization while empowering survivors to heal and rebuild autonomy in supportive, respectful environments (The Jean Tweed Centre, 2013). The importance of applying trauma-informed harm reduction approaches in DV shelters is underscored by the fact that many substance use treatment services still lack these principles. A lack of trauma-informed treatment programs can itself be a barrier for survivors, as traditional approaches often emphasize individual accountability and responsibility in ways that may deepen feelings of shame and self-blame related to their experiences of abuse (Phillips et al., 2020b).

Building on these principles, many researchers emphasize that implementing harm reduction and trauma-informed care in DV shelters is most effective when supported by coordinated and integrated service models. Emerging research and practice-based evidence indicate that coordinated and integrated service models can substantially improve support and outcomes for survivors who use substances (Bailey et al., 2019; Armstrong et al., 2019; Mason & O'Rinn, 2014; Macy & Goodbourn, 2012; Bennett & O'Brien, 2010; Bennett & Bland, 2008). To clarify the terminology: **coordinated service models** refer to systems in which DV and substance use treatment programs operate separately but maintain strong communication, feedback, and cross-referral processes (Bennett & Bland, 2008). **Co-located service models** involve staff from one system (e.g., substance use treatment) being physically based within the other (e.g., a DV program), allowing for more immediate collaboration (Macy & Goodbourn, 2012). **Integrated service models**, by contrast, provide both DV and substance use services within a single program or facility (Bennett & Bland, 2008). Given the frequent co-occurrence of substance use, mood and anxiety disorders, and trauma among survivors, these service models are grounded in the core principle that trauma-informed care is essential for effectively meeting survivors' complex needs (*The connection between sexual assault and substance abuse*, n.d.).

2.3. Identifying and Assessing Potential Risks of Harm Reduction Approaches

While research provides strong evidence that more tolerant, harm reduction-oriented policies in DV shelters can improve outcomes for survivors who use substances, it remains essential to

develop a thorough, well-informed understanding of potential risk factors affecting all parties involved. This subsection aims to identify and examine both perceived and actual risks associated with adopting a harm reduction approach to substance use in DV shelters. The next subsection, “Mitigating Risk,” will then explore evidence-based strategies from the literature to reduce and manage these risks.

The main risks identified for survivors entering DV shelters while actively using substances center on both safety concerns and perceived behavioral challenges. Many shelter providers express concern that residents’ active use can pose physical safety risks to the users themselves and that associated using behaviors may create risks for other residents, children, and staff (Martin et al., 2008; Morton et al., 2015). There is also a common belief that survivors who are actively using may be less able to comply with shelter rules, may be dishonest or untrustworthy, neglectful of their children and parental responsibilities, or unmotivated to work toward goals related to their eventual discharge from shelter (Zubretsky, 2002).

Implementing harm reduction practices in DV shelters also requires careful attention to the potential risks for residents who do not use substances. Substance-related practices can be emotionally triggering for other survivors, particularly for those with histories of violence by substance-using partners, where the abuse was attributed to substance use itself (Hovery et al., 2019). Some residents have reported feeling unable to tolerate sharing space with individuals who are actively using, and exposure to substance use within shelter settings has been cited as negatively impacting those who do not use, especially when policies are unclear or inconsistently enforced (Hovey et al., 2019). These dynamics raise concerns that shelters perceived as tolerant of substance use could discourage survivors who do not use substances from seeking services (Schumaker & Holt, 2012; Martin et al., 2008). In Hovey et al.’s (2019) study, many staff reported that balancing the safety and comfort of all residents, both users and non-users, has been a key challenge in integrating harm reduction approaches in housing settings. While these concerns are frequently cited, it is important to recognize that research consistently demonstrates a high prevalence of substance use histories among survivors, suggesting that centering harm reduction practices may better reflect the realities and needs of the shelter population overall.

Staff capacity and training are also critical considerations when implementing harm reduction approaches. Many programs face limitations such as single-staff coverage during overnight shifts or generally insufficient staffing to effectively manage behavioral situations that can arise with active substance use (Hovey et al., 2019). Additionally, a lack of training on substance use, harm reduction principles, and trauma-informed practices can leave staff feeling unprepared to respond appropriately to residents’ needs (Hovey et al., 2019). These challenges underscore the importance of investing in adequate staffing levels and comprehensive trainings to support the safe and effective integration of harm reduction approaches in shelter settings.

2.4. Mitigating Risk: Best Practices for Effective Implementation of Harm Reduction

Mitigating risk is a core practice within harm reduction, helping to make it safer and more workable in settings like DV shelters. Although research on survivors’ experiences in shelters using harm reduction models remains limited, available studies offer valuable insights. Survivors

and practitioners have shared feedback on what works well, what needs improvement, and how harm reduction practices can be refined to better address potential risks and enhance their integration in shelter environments.

In a unique study that gathered data directly from survivors, Hovey and Scott (2019) interviewed 25 former residents about their experiences with a harm reduction service delivery model at a Canadian Violence Against Women (VAW) shelter. They found that participants' experiences and perceptions of safety strongly shaped their views on what effective harm reduction should look like. Many valued the nonjudgmental, open atmosphere created by staff's neutral stance on substance use. However, others felt that this approach sometimes meant staff expected residents to tolerate substance use even when it was emotionally triggering. About half of the women from the study—including both those who used substances and those who did not—reported being triggered by others' substance use, linking these reactions to their own past trauma and highlighting the need for greater staff support in managing these challenges.

Participant feedback from Hovey and Scott's (2019) study emphasized the importance of clear, consistently enforced guidelines about acceptable behavior, noting that ambiguity undermined safety. Participants recommended developing clear procedures not only for residents but also for staff to better understand their roles in supporting harm reduction while managing behavioral conflicts. They also highlighted the need for comprehensive staff training in harm reduction philosophy and trauma-informed approaches to better balance competing needs, respond sensitively to trauma, and ensure safety for all residents. Finally, many participants suggested adapting the physical layout of shelters, such as creating separate wings for residents with children or those using substances, to reduce exposure to potentially triggering behaviors.

These survivor-identified strategies align closely with national recommendations prioritizing risk mitigation. The National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) emphasizes building strong cross-referral processes between DV programs and substance use treatment providers to sustain collaborative work, develop staff expertise, and increase confidence in managing referrals (Phillips et al., 2020b). They also recommend joint training that covers IPV, substance use coercion, treatment options, overdose response, and harm reduction practices to help staff address these concerns, connect survivors with resources, and engage in trauma-informed, harm reduction-focused conversations about substance use. This training reduces staff fears about working with survivors who are actively using, challenges harmful beliefs (e.g., equating all substance use with addiction), and supports recognizing substance use as a potential coping strategy for IPV (Phillips et al., 2020b).

Muth et al.'s (2024) scoping review further reinforces and expands these recommendations by systematically analyzing 21 relevant studies on harm reduction in emergency women's shelters. Their findings echo both Hovey and Scott's survivor feedback and NCDVTMH's national guidance, underscoring the importance of comprehensive staff training, clear and accessible policies, and an organizational philosophy that understands substance use as often connected to survivors coping with IPV. Additionally, they highlight both shelter-based strategies—like open communication about substance use, survivor-centered approaches, and addressing behaviors without punitive responses—and community-based strategies, including formal referral

processes and partnerships with substance use agencies for on-site support. Taken together, these overlapping themes suggest a convergence of best-practice recommendations across the literature. Effective harm reduction in DV shelters requires not only clear policies and consistent enforcement but also sustained investment in staff training, collaborative partnerships, integrated services, and supportive organizational cultures that prioritize survivor safety, autonomy, and dignity.

Suggestions for Further Reading:

BC Society of Transition Houses (BCSTH). (2011). *Reducing barriers to support for women fleeing violence: A toolkit for supporting women with varying levels of mental wellness and substance use.* https://bcsth.ca/wp-content/uploads/2015/11/ReducingBarrierToolkit.pdf

Hovey, A., Roberts, C., Scott, S., & Chambers, L. (2019). Understanding the landscape of substance use management practices in domestic violence shelters across Ontario. *Journal of Family Violence, 35,* 191–201. https://doi.org/10.1007/s10896-019-00056-0

Muth, E., Hovey, A., Brownlee, K., & Scott, S. (2024). Barriers and facilitators to implementing harm reduction in emergency women's shelters - implications for practice: A scoping review. *Human Service Organizations: Management, Leadership & Governance*, *48*(5), 555–581. https://doi.org/10.1080/23303131.2023.2287741

Phillips, H., Warshaw, C., & Kaewken, O. (2020a). *Literature review: Intimate partner violence, substance use coercion, and the need for integrated service models*. National Center on Domestic Violence, Trauma, and Mental Health. https://ncdvtmh.org/wp-content/uploads/2022/10/Substance-Use-Coercion-Literature-Review.pdf

The Jean Tweed Centre for Women & Their Families (2013). *Trauma matters: Guidelines for trauma-informed practices in women' s substance use services*. Toronto: The Jean Tweed Centre. https://jeantweed.com/wp-content/uploads/2021/11/Trauma-Matters-online-version-August-2013.pdf

Warshaw, C. & Tinnon, E. (2018). *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*. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health. http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2018/03/NCDVTMH_MHSUCoercionToolkit2018.pdf

3. Findings from Participant Interviews

The interviews revealed a wide range of perspectives on Haven's proposed substance-use policy, with most participants expressing strong support for the change while still identifying important risks and implementation challenges. Their reflections often echoed themes from the literature, highlighting both the potential benefits of harm reduction in shelter settings and the complexities it introduces.

These findings are based on qualitative interviews with seven Haven staff members and one resident. Efforts were made over several months to gather additional resident perspectives, including the option to provide feedback through an anonymous survey, but only one resident ultimately participated. While limited, this perspective provides important insight when considered alongside the views of staff, highlighting both shared concerns and unique resident experiences.

Overall, participants emphasized the policy's potential to strengthen empowerment, safety, and trust, yet every interviewee also raised concerns about trauma triggers, enforcement, or staff capacity. Even the one participant who remained skeptical acknowledged possible benefits and pointed to conditions under which the policy might succeed. Taken together, the interviews highlight both optimism about the policy's alignment with Haven's survivor-centered philosophy and caution about the safeguards and supports needed to make it work effectively.

3.1. Anticipated Benefits of Substance-Use Policy Change

3.1.1. Autonomy and Empowerment

The most frequently cited benefit of the new substance-use policy was its alignment with Haven's empowerment model. Allowing alcohol on campus was seen as a concrete way of putting choices back in survivors' hands, affirming their dignity, and helping them feel at home. As one advocate explained, "Many residents are coming from environments where they've experienced intense control, so being in a space that recognizes their right to make decisions about their bodies and coping strategies can be a powerful step towards rebuilding senses of agency and self-trust."

Participants also emphasized how the change could encourage survivors to "show up as they are," breaking cycles of control that otherwise risk making shelter feel like "going from one controlling household to another." One described the shift as helping the shelter "feel more like a home rather than… a temporary shelter" defined by rules and restrictions. In this way, the policy was directly tied to Haven's philosophy of empowerment and survivor-centered care.

Several interviewees framed the policy as preparation for the realities of long-term housing. Within a supportive environment, residents could practice balancing autonomy with accountability, skills directly transferable to settings where landlords and neighbors set expectations. This balance between freedom and responsibility was seen as essential to both agency and stability beyond shelter.

These insights echo the broader literature on empowerment and harm reduction, which warns against replicating abusive power dynamics through rigid rules (Phillips et al., 2020b). In contrast, harm reduction approaches affirm survivor autonomy, encourage openness without fear of punishment, and strengthen self-determination as a protective factor against retraumatization (Muth et al., 2024).

3.1.2. Safer and More Supportive Outcomes

Interviewees identified several ways the policy change could improve resident safety. Some emphasized practical benefits, such as reducing the risk of unsafe withdrawal, lowering the chances of drinking and driving, and decreasing policy violations that might otherwise require disciplinary action. Others emphasized benefits with more of a survivor-centered focus, such as reducing the need to leave campus to use substances, creating safer and more supportive environments for use, and strengthening advocate-survivor relationships in ways that build trust and expand access to resources.

A number of participants stressed that reducing the need to go off-site was especially important for safety. Leaving shelter to drink exposes survivors to risks such as encountering abusers in public or traveling under unsafe conditions. One advocate recalled a resident who was found by her abuser while drinking in a nearby park, illustrating how the zero-tolerance policy could unintentionally put people in danger. From this perspective, permitting alcohol on campus gives survivors the option to remain within a safer environment.

Others highlighted how the policy might foster safety in ways similar to supervised use models. If residents can drink in their rooms or designated spaces, advocates remain “a building away or a phone call away,” able to provide immediate support if needed. This proximity was framed as a way to reduce risks while simultaneously strengthening nonjudgmental, supportive relationships between survivors and staff.

Finally, many participants underscored the potential to reduce stigma and build trust. When residents know their choices will not automatically result in punishment, they may feel more comfortable disclosing substance use. This openness allows advocates to provide tailored safety planning, harm reduction tools, and referrals to outside resources. Even though alcohol is the only substance formally permitted under the new policy, interviewees noted that the cultural shift could encourage more honest conversations about other forms of use, creating space for stronger support and planning.

These perspectives align with findings from harm reduction research in DV shelters. Studies in Canada and the U.S. show that when residents can be open about substance use, safety planning improves, staff-survivor trust deepens, and unsafe behaviors decrease (Hovey & Scott, 2019; Lee & Zerai, 2010). Ultimately, safety is achieved not through prohibition, but through supportive structures that recognize substance use as a reality in many survivors’ lives and prioritize harm reduction to minimize risks (Muth et al., 2024).

3.2. Risks and Concerns

3.2.1. Managing Trauma and Triggers

The most commonly raised concern across interviews was that allowing alcohol could retraumatize survivors or jeopardize sobriety. All eight participants emphasized this risk, noting that many residents arrive at shelter either actively in recovery or carrying painful histories of substance-related abuse.

Several advocates stressed that sobriety has been a cornerstone of stability for some survivors. One explained, “The current environment where alcohol isn’t present has been really essential to maintaining their sobriety. I’ve heard directly from some residents how absence of alcohol has provided a sense of structure and safety that’s been supportive.” Others feared that introducing alcohol would recreate the dynamics of past abuse, provoking fear, flashbacks, or anxiety.

Even indirect exposure was described as triggering. Participants pointed out that something as subtle as the smell of alcohol on someone’s breath, empty cans in waste bins, or even knowing that others were drinking nearby could reignite trauma tied to substance-fueled abuse. As one advocate shared, “We already get people who let us know that others are drinking in shelter and it really triggers them. That’s going to be harder to navigate if it’s permitted.”

Taken together, these reflections highlight a fundamental tension: while harm reduction lowers barriers to shelter entry, it can also expose residents to triggers that could compromise healing. Even with safeguards like limiting alcohol use to private rooms, interviewees questioned whether the shelter could truly protect residents from the emotional and psychological consequences of substance use in the environment.

The literature echoes these concerns. Studies show that exposure to substances in shelter settings can be deeply triggering for survivors, particularly when substance use was central to their abuse (Hovey & Scott, 2019). While harm reduction models are designed to promote inclusion, scholars caution that poorly managed policies risk retraumatizing survivors and undermining feelings of safety (Schumaker & Holt, 2012; Phillips et al., 2020b). The challenge lies in striking a balance between reducing barriers and ensuring that survivors feel secure, supported, and able to heal.

3.2.2. Policy Enforcement and Behavioral Conflicts

Beyond trauma and triggers, participants raised concerns about how the new policy would be enforced in practice. Their reflections centered around three issues: consistency, resident conflict, and staff capacity.

Policy consistency was a recurring theme, particularly around marijuana. As one advocate noted, “For many residents, marijuana serves as a significant coping mechanism, and excluding it while permitting alcohol may reinforce harmful stereotypes and create a sense of inequity.” Others suggested marijuana may pose fewer risks than alcohol and argued it might be a more appropriate fit within a harm reduction framework. One resident expressed frustration not with restrictions on smoking, but with the inability to store cannabis on campus: “I completely understand it not being in my room…But I don’t understand why you just can’t store it for me… I’m not asking to do it on campus as I respect that rule, but I just don’t understand why you just can’t store it.” From this perspective, allowing alcohol while prohibiting even the storage of

cannabis felt inconsistent with harm reduction principles and risked undermining residents' sense of fairness in how the policy was applied.

Resident conflict was another anticipated challenge. Shelter relationships are often close and supportive, but participants noted that these ties have also lead to off-site drinking or pressure to use substances together. For residents working hard to maintain sobriety, such dynamics can create strain and complicate relationships. Advocates worried alcohol use could intensify disputes, making it "ten times harder to de-escalate, to understand what happened, to support."

Finally, staff burden and enforcement emerged as a major concern. Participants questioned whether the policy could be monitored consistently, especially during evenings when staff coverage is limited. Many predicted an increase in both the frequency and intensity of behavioral conflicts, which would place greater responsibility on advocates for de-escalation and crisis management. Without additional training or resources, participants feared staff could face heightened stress and burnout.

Research has pointed to similar challenges, highlighting the difficulty of balancing consistent enforcement with resident autonomy, especially when staff capacity is stretched (Hovey & Scott, 2019). Scholars noted that staff often feel underprepared to manage substance-related conflicts, with inadequate training and limited institutional support exacerbating risk of burnout (Phillips et al., 2020b). While harm reduction frameworks can reduce stigma and expand access, they are most effective with sustained investments in staff training and resources (Muth et al., 2024).

3.2.3. Resident and Child Safety Concerns

The final set of concerns centered on safety risks tied to alcohol use in a communal environment where families and children share space. Participants highlighted issues ranging from the possibility of alcohol poisoning during overnight hours when staff coverage is limited, to the dangers of accidental ingestion or exposure in shared areas.

Several also reflected on how impaired judgment and behavioral changes can pose risks when residents are intoxicated. As one put it, "Drunk people might just be a little bit more dangerous in a sense, especially when you're living in a hypervigilant state." These concerns were not framed as moral judgments but as recognition that intoxication can increase the likelihood of conflict, unpredictable behavior, or unsafe interactions in an already fragile environment. While some expressed trust that residents would balance autonomy with responsibility, others worried that intoxication could impair decision-making and make it harder for individuals to follow policies or keep themselves safe when coming and going from campus.

Together, these perspectives highlight the delicate balance between autonomy and safety within harm reduction frameworks. While participants acknowledged safeguards such as lock boxes and room restrictions as important steps, they cautioned that alcohol's presence could still heighten risks for children, intensify conflict, and challenge Haven's ability to ensure resident safety. These concerns mirror findings in the literature, where staff and survivors alike have observed that substances in shelter settings can magnify risks unless paired with clear policies and consistent enforcement (Hovey & Scott, 2019; Phillips et al., 2020b).

3.3. Suggestions for Guidelines and Implementation

3.3.1. Clear and Consistent Guidelines

Interviewees emphasized that the success of the new policy will depend on guidelines that are clear, consistent, and well-communicated. Strong policies were seen as essential for avoiding confusion, reducing retraumatization from uneven enforcement, and creating a shared framework of accountability for both residents and staff.

Participants stressed the need to reinforce expectations around physical boundaries and interpersonal conduct, particularly given past incidents of harm among residents. Recommendations included prohibiting intimate relationships within shelter, clarifying expectations around consent and physical touch, and communicating these rules during intake, house meetings, and one-on-one check-ins. Advocates added that these conversations should emphasize behavioral expectations related to substance use, ensuring that residents are not caught off guard or singled out when violations occur.

In response to concerns about enforcement, one resident suggested structuring use in ways that balance autonomy with accountability. They argued that solitary drinking could heighten risks, while social use in designated spaces might provide more oversight and reduce escalation. To address this, they proposed separate wings for residents who prefer sobriety and those who drink, or creating specific areas where alcohol could be consumed. While acknowledging that “you’re not gonna please everyone,” these ideas illustrate how shelter layout and designated spaces can shape resident experiences and perceptions of safety. Similar suggestions appear in the literature: Hovey and Scott (2019), for example, found that survivors themselves advocated for distinct spaces to reduce exposure to substance use and protect residents who might otherwise feel unsafe or triggered.

Finally, several interviewees pointed to the importance of clarifying staff roles and capacity. They maintained that residents should be informed that staff cannot provide medical care or remain overnight, and that in emergencies they must call 911. Clear communication of these boundaries was seen as critical for setting realistic expectations while maintaining transparency about the support advocates can and cannot provide, a point echoed in the literature, which emphasized that shelters function most effectively when both residents and staff share a clear understanding of expectations and limits (Phillips et al., 2020b; Hovey & Scott, 2019).

3.3.2. Staff Training and Support

Nearly all interviewees stressed that successful implementation of the new policy will require robust staff training and ongoing support. They anticipated that alcohol use could add complexity to already demanding work, making it essential that advocates feel equipped and confident.

Education and resources were identified as a top priority. Participants wanted access to research and examples from other shelters that have adopted harm reduction policies, along with concrete tools for safety planning and substance-specific referrals. As one advocate admitted, “If someone came over and asked for [support for substance use], I would just Google

it and I don't know what the best resources are." Accessible, substance-focused materials were seen as essential for providing consistent and informed support.

Training in harm reduction and de-escalation was another recurring theme. Advocates pointed out that alcohol can alter behavior in unpredictable ways, underscoring the need for practical skills to manage conflict and support residents under the influence. Suggested approaches included targeted harm reduction instruction and role-playing exercises, which would allow staff to practice real scenarios, make mistakes, and build confidence in navigating challenging interactions.

Interviewees also highlighted the importance of managerial support and open communication. Advocates wanted reassurance that supervisors would step in when needed, rather than leaving frontline staff to shoulder responsibility alone. They also emphasized the value of regular feedback loops so that staff could voice concerns and help refine policy as issues arise. As one put it, "The key is just going to be flexibility as we go… adjusting policies or the way that we navigate things as we move forward."

In addition, some noted the importance of medical response training and preparedness. This included CPR, recognizing signs of alcohol poisoning, and knowing when to involve emergency services. A few even suggested stocking harm reduction supplies such as Narcan, arguing that being prepared for a broader range of risks would strengthen overall safety, even if alcohol is the only substance formally permitted on site.

These discussions underscored that training is not just about technical skills, but also about staff wellbeing. Without adequate preparation and institutional support, advocates risk facing heightened stress and burnout. Echoing the literature (Muth et al., 2024; Hovey & Scott, 2019), sustained investment in education, resources, and communication was seen as critical for ensuring staff feel supported and capable of providing survivor-centered care under the new policy.

3.3.3. Resident Education and Support

Interviewees emphasized that residents, like staff, need clear communication, education, and ongoing support for the new policy to succeed. Their reflections focused on transparency, inclusion, and equipping residents with knowledge to foster respectful cohabitation.

Several participants stressed the importance of explaining not only what the policy entails, but also why Haven is making the shift and how it aligns with the organization's philosophy of empowerment and harm reduction. As one advocate explained, the key is "being as transparent as possible with residents about these changes… and again, just hoping there's that shift of, like, still please come to us if this is not feeling good." Structured check-ins at one week, one month, and six months after implementation were recommended to monitor both short- and long-term impacts, while also encouraging feedback and open dialogue. To further strengthen communication, another advocate suggested anonymous reporting options, noting that some residents may hesitate to raise concerns directly out of fear of retaliation. Together, these

strategies were framed as ways to build trust, normalize feedback, and ensure resident voices are consistently included in shaping how the policy evolves.

Education was also viewed as central to maintaining safe and respectful environments. Advocates highlighted the need to equip residents with information on boundaries, consent, and cohabitation, particularly given that substance use could complicate relationships or shared living dynamics. By setting clear expectations and providing practical tools, staff hoped to reduce conflict and ensure residents feel safe, respected, and supported.

3.3.4. Community Partnerships

Several participants emphasized that successful implementation of the new policy cannot rest solely on Haven staff. While advocates play a crucial role in providing survivor-centered support, they are not substance use specialists and should not be expected to take on that expertise alone. Building strong community partnerships was described as critical for ensuring survivors have access to the professional care and resources they need.

A resident proposed partnering with an offsite sobriety or substance use clinic, creating a clear pathway for survivors who want additional professional support. Others underscored the value of involving trained substance use counselors, either through partnerships with local organizations or via a dedicated support line, who could be available to residents as needed. These supports were seen as especially vital for survivors whose trauma histories are intertwined with substance use or for those navigating recovery.

Interviewees stressed that any external providers must share Haven's empowerment philosophy. One survivor expressed frustration with treatment models that dismissed their autonomy, describing how prescriptive approaches left them feeling unsupported. In contrast, an empowerment-based model was seen as more respectful and effective, affirming survivors' right to make choices while helping them manage risks.

These reflections highlight the importance of collaborative, empowerment-oriented partnerships with substance use professionals and community organizations—a need indicated in the literature. Research shows that integrated service models improve outcomes for survivors by bridging expertise between DV programs and substance use providers (Bennett & Bland, 2008; Macy & Goodbourn, 2012; Bailey et al., 2019). Such collaborations expand the capacity of shelter advocates, reduce the risk of burnout, and ensure survivors receive specialized, nonjudgmental support tailored to their diverse needs (Muth et al., 2024; Phillips et al., 2020b).

4. Final Recommendations for Policy and Practice

The following recommendations draw on participant feedback and existing research to balance survivor autonomy with safety while equipping staff with the tools to implement the new policy effectively. Short-term actions focus on staff and resident preparation through training, clear communication, and feedback processes. Long-term strategies emphasize building sustainable partnerships and expanding specialized care. Finally, detailed guidelines and procedures provide consistent expectations and accountability to support a safe, transparent, and survivor-centered environment.

4.1. Short-Term Actions

Staff Preparation:

- Disseminate this report across all staff to foster transparency and provide an immediate opportunity for collective education.
- Develop targeted training programs with concrete tools for safety planning and substance-specific referrals. These should emphasize:
    - Harm reduction philosophy and trauma-informed approaches to balance competing needs and respond sensitively to survivor trauma.
    - Practical conflict management strategies, including role-playing exercises, so staff can practice real scenarios, build confidence, and learn from mistakes in a safe environment.
- Provide or share local opportunities for medical response training (e.g., CPR, overdose recognition, Naloxone administration) and stock harm reduction supplies such as Narcan, even if alcohol remains the only substance formally permitted.

Resident Preparation:

- Communicate the rationale behind the policy change, connecting it explicitly to Haven's empowerment model and harm reduction philosophy.
- Introduce rules and expectations consistently at intake, in house meetings, and during one-on-one check-ins.
- Create separate wings or designated areas for families with children and residents who use substances. This approach, echoed in research (Hovey & Scott, 2019), reduces exposure to potentially triggering behaviors and strengthens perceptions of safety.
- Clarify staff roles and limits to residents, including the fact that advocates cannot provide medical care or remain overnight, and that emergencies require calling 911.
- Equip residents with education on boundaries, consent, and cohabitation, with particular attention to how substance use can complicate shared living dynamics.
- Create channels for anonymous feedback to allow residents to raise concerns without fear of retaliation.

4.2. Long-Term Actions

Community Partnerships:

- Build and strengthen partnerships with community-based organizations (CBOs) and treatment providers to extend specialized care beyond what Haven staff can provide. As

participants emphasized, successful implementation cannot rest solely on advocates, who are not substance use specialists.

- Seek grant funding to support off-site treatment referrals, on-site professional substance use counseling, or a dedicated support line for residents navigating recovery.
- Follow NCDVTMH recommendations for cross-referral processes and joint training with substance use treatment providers, ensuring staff gain confidence in managing referrals and conducting trauma-informed, harm reduction-focused conversations.

4.3. Guidelines and Procedures

1. Behavioral Expectations:
    - Substance use locations: Alcohol may only be consumed in resident bedrooms or designated communal areas identified by staff. Alcohol is not permitted in children's playrooms, dining areas, or other family spaces.
    - Safe storage: All alcohol must be kept in locked boxes provided by Haven when not in use. Open containers are not permitted outside approved spaces.
    - Interpersonal conduct: Residents must respect physical boundaries and consent. Unwanted touch, harassment, or pressure to use substances with others will not be tolerated.
    - Relationships: Romantic or sexual relationships between residents are prohibited while in shelter to reduce risks of coercion or conflict.
    - Child safety protocols: Alcohol use is strictly prohibited in spaces designated for children. Any incident involving children and alcohol automatically escalates to supervisor review to ensure immediate and appropriate intervention.
2. Accountability and Enforcement:
    - Graduated response: Violations will be addressed first through supportive conversations and reminders of expectations. Repeated or serious violations (e.g., intoxication leading to unsafe behavior) will result in a written warning and individualized safety planning. Only ongoing or severe violations (e.g., threats of violence, child endangerment) will trigger removal from the program.
    - De-escalation protocols: When residents are intoxicated and disruptive, staff will follow a step-by-step response protocol: begin with verbal de-escalation, involve a supervisor if behavior escalates, engage in safety planning where possible, and involve law enforcement only as a last resort. This process ensures consistent, trauma-informed responses and reduces staff uncertainty.
    - Documentation: All violations and staff interventions should be documented in a shared log accessible to supervisors to ensure consistency. When a violation

results in a written warning, the resident will be asked to sign the form to confirm their understanding.

- Trauma-informed enforcement language: All enforcement conversations should be framed in supportive, non-punitive terms, such as emphasizing safety planning rather than discipline. This approach reduces the risk of replicating controlling dynamics survivors may have experienced in past abusive relationships.
- Consistency: Enforcement must be applied equally to all residents to avoid perceptions of favoritism or retraumatization through selective enforcement.

3. Resident Engagement:
    - Orientation: Upon intake, each resident will receive a plain-language orientation outlining the substance-use policy, the reasons behind it, and expectations for behavior. Staff will review the policy verbally to ensure understanding.
    - Feedback channels: Residents may share concerns through anonymous feedback boxes or online forms. These will be reviewed weekly by supervisors, and follow-up steps will be shared transparently with the community.
    - Check-ins: Structured check-ins will be held at one week, one month, and six months after policy implementation to gather resident perspectives and adjust procedures as needed.
4. Staff Support:
    - Role clarity: Advocates are responsible for policy education, supportive interventions, and conflict de-escalation but are not medical providers. Residents will be reminded that medical emergencies must be handled by calling 911.
    - Training: All staff will receive harm reduction, trauma-informed care, and de-escalation training twice annually. Role-playing scenarios will be incorporated into training to practice responding to intoxication-related incidents.
    - Ongoing staff support: Supervisors will hold weekly debriefs with staff to review incidents, reinforce consistent enforcement, and identify staff support needs.

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