NATIONAL CENTER ON
DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH

Recommendations: National Action Plan on Gender-Based Violence

This document highlights practical, concrete areas that the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) believes should be addressed in the Gender Based Violence National Action Plan. Implementation of these recommendations -- which start with some cross-sector changes and then include some issue-specific recommendations on telehealth, maternal health outcomes, national suicide prevention helpline, among others -- would increase the effectiveness of programs and services to support survivors who experience mental health and substance use-related effects of gender-based violence and other trauma. It is critical that the National Action Plan includes a focus on survivors who experience these complex needs.

Background: Research over the past 35 years has consistently demonstrated that experiencing abuse by an intimate partner is associated with a wide range of mental health and substance use-related consequences. Both clinical and population-based studies indicate that victimization by an intimate partner places people at significantly higher risk for depression, anxiety, posttraumatic stress disorder, substance use, and suicide attempts, whether or not they have suffered physical injury. In addition, people who abuse their partners engage in coercive tactics related to their partner's mental health or substance use. These tactics - known as mental health and substance use coercion - are discussed in more detail below but are part of a broader pattern of abuse and control designed to undermine a partner's sanity, coerce them into using substances, sabotage their recovery, and then discredit them with potential sources of protection and support.[1]

The COVID-19 pandemic has exacerbated the gender-based violence crisis in our country and at the same time, increased the demand for mental health and substance use disorder services. In 2019, NCDVTMH conducted a needs assessment of over 570 local and tribal domestic violence programs on their capacity to meet the needs of survivors and their children related to substance use or mental health. Prior to COVID, over 70 percent of the domestic violence programs saw an increased need for mental health and substance use services within domestic violence programs, yet the vast majority felt unprepared to meet this critical need.

Recommendation: Support Systems Change on Substance Use, Mental Health, and Intimate Partner Violence - Ensure that the mental health and substance use disorder treatment and recovery systems are equipped to address the unique needs of domestic violence and sexual assault survivors and their children

In 2019, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Administration on Children and Families (ACF), released an Information Memo, originally developed during the previous Administration with the National Center on Domestic Violence, Trauma and Mental Health (NCDVTMH), calling for *Collaboration at the Intersection of Domestic Violence, Mental Health, and Substance Use*. The SAMHSA/ACF Information Memo highlights the mental health and substance use-related effects of domestic violence, including abusive tactics targeted towards a partners' mental health and substance use, and the need for more integrated/collaborative approaches for supporting survivors of domestic violence and their families.

Continuing to highlight the need for cross-system collaboration, research has also consistently demonstrated high rates of domestic violence among people accessing services in mental health and substance use disorder treatment settings.[2] And yet treatment providers are often unaware of the service barriers and safety risks posed

[1]Warshaw et al. (2014). MH & SUCoercion Surveys Report from NCDVTMH and NDVH (pp. 1–26).
[2] Phillips, 2014; Dillon, Hussain, Loxton, & Rahman; Nathanson, Shorey, Tirone, & Rhatigan, 2012; Trevillion, Oram, Feder, & Howard, 2012; Howard, Oram, Galley, Trevillion, & Feder,2013; Riviera et al., 2015; Warshaw, Brasher, and Gill, 2009

by abusive partners, including those related to mental health and substance use coercion.[3] They are frequently unprepared to address the complex issues survivors face.

At the same time, survivors and their children are coming to domestic violence programs with more complex mental health and substance use concerns; this is exacerbated by the lack of mental health and substance use disorder treatment providers in many areas[4]. Domestic violence programs therefore struggle to support survivors with mental health and substance use-related needs: only 12% of domestic violence programs are "very prepared" to meet the needs of survivors with disabling mental health conditions, 20% are "very prepared" to meet the needs of survivors who use substances, and 16% are "very prepared" to meet the needs of children and youth with behavioral and mental health challenges.[x] Domestic violence programs and coalitions continue to report challenges in working with mental health and substance use disorder treatment systems including the limited availability of services; affordable, multilingual services that are culturally relevant, gender-responsive, accessible to parents; and both domestic violence and trauma informed[5].

A NCDVTMH study of 3,025 callers to the National Domestic Violence Hotline found high rates of abuse specifically targeting domestic violence survivors' substance use and/or mental health. As a result, ASPE and ACF now recognize "substance use coercion," as a form of abuse in which perpetrators of intimate partner violence undermine and control their partners through tactics such as introducing a partner to substances, coercing them to use, actively keep them from meeting treatment and recovery goals, and then using their substance use to discredit them with the courts, family, and friends.

More than 60 percent of survivors who sought help for substance use said their abusive partners tried to prevent them from accessing treatment. And among women accessing substance use disorder treatment, 47-90 percent reported experiencing domestic violence in their lifetime and 31-67 percent in the past year. The recent *Substance Use Coercion as a Barrier to Safety, Recovery, and Economic Stability* report finds only 19% of state substance use disorder treatment systems have solid partnerships with domestic violence agencies[6]. A similar constellation of issues was found with "**mental health coercion**" where 50% reported that their partners had threatened to report to authorities that they were "crazy" to keep them from getting something they want or need (e.g., custody of children, medication, protective order).

Yet, throughout the ongoing opioid epidemic, and now during COVID-19 pandemic and recovery, the mental health and substance use disorder treatment system remains vastly unprepared to meet the needs of survivors. Survivors of domestic and sexual violence have unique needs with regard to how services and treatment are delivered and how privacy is maintained, especially with the expansion of telehealth services during the pandemic. Greater support for culturally specific and Indigenous approaches to services that address historical trauma and institutionalized oppression for survivors is also an important priority.

Specific recommendations:

- **Support the establishment of a strong working partnership between the FVPSA program and the Office on Women's Health (OWH) to incentivize collaboration at the state and local level around the intersection of intimate partner violence (IPV), mental health and substance use, including state-level**

[3] Warshaw & Tinnon (2018). Coercion related to MH and SU in the context of IPV: A toolkit for screening, assessment, and brief counseling in primary care and behavioral health settings. NCDVTMH

[4] Phillips, Kaewken, Lyon, (2021). Needs Assessment on Mental Health & Substance Use Challenges. NCDVTMH

[5] Macy, R. J., & Goodbourn, M. (2012). Promoting successful collaborations between domestic violence and substance abuse treatment service sectors: A review of the literature. Trauma, Violence, & Abuse, 13(4), 234-251.

[6] National Center on Domestic Violence, Trauma and Mental Health (NCDVTMH) and the National Association of State Alcohol and Drug Abuse Administrators (NASADAD) (2019). Summary of Key Results: Addressing Domestic Violence and Substance Use Disorders. Chicago, IL. NCDVTMH.

pilot programs that include a focus on substance use coercion. The Violence Against Women Act's Health Title authorizes a State partnership initiative through OWH. We recommend that the OWH work in conjunction with the FVPSA program to continue the State Partnership initiative. As part of the State Partnership initiative, we also recommend that OWH create a separate Tribal/state-level pilot program to incentivize substance use disorder treatment providers to be trained on intimate partner violence. The pilot program would also include partnerships with domestic and sexual violence organizations at the tribal, state, and local level to address the intersections of intimate partner violence, substance use disorder, and substance use coercion.

- **Promote collaboration between the domestic violence, mental health, and substance use disorder (SUD) treatment and recovery fields to improve services for survivors of intimate partner and sexual violence and their children.**
    a. Encourage ACF and SAMHSA to fulfill their commitment as outlined in the HHS Information Memo to support state mental health and substance use disorder treatment directors as well as state and territory Family Violence Prevention and Services Act Administrators and leaders in the domestic violence field to forge effective partnerships and develop collaborative efforts to service survivors and family members impacted by domestic violence. As these partnerships occur on the state level, support funding for training and technical assistance for the mental health and substance use disorder fields on domestic violence and sexual assault, including gender- and culturally responsive, trauma-informed approaches.
    b. Develop inter-agency mechanisms to ensure that COVID-19 relief and other programs focused on mental health, suicide prevention, substance use disorder treatment and/or recovery support services include attention to the unique barriers faced by survivors and their children, and that survivors' needs are appropriately addressed through consultation with experts in the fields of domestic violence and sexual assault, including the FVPSA program. Incorporate guidance on telehealth safety, privacy, and confidentiality concerns for survivors accessing mental health and SUD treatment.
    c. Issue guidance requiring training and TA on domestic violence, substance use, and substance use coercion for opioid treatment programs and medication assisted treatment (MAT) providers in primary care, mental health, and SUD treatment settings and encouraging the inclusion of DV experts in federally-funded state opioid initiatives.

- **Fund research on the prevalence and impact substance use coercion, on effective interventions, on and the economic costs of substance use coercion.**
    a. Support interagency partnerships between FVPSA, NIMH/NIDA, SAMHSA, and the CDC to develop and promote a research agenda on the intersections of domestic violence and substance use coercion
    b. Encourage the CDC and SAMHSA to include questions about mental health and substance use coercion in national surveys such as the National Intimate Partner and Sexual Violence Survey (NISVS), the National Survey on Drug Use and Health (NSDUH), and the Behavioral Risk Factor Surveillance System (BRFSS) Survey.

- **Support family-centered, trauma-informed services for children, including children exposed to domestic violence in a range of settings, including youth homelessness providers, schools, foster care, childcare, and child welfare. Promote policies that support the ability of survivors to maintain custody of their children.** The constellation of DV, substance use, and mental health is major contributor to child removal yet, the intersections between these factors (traumatic effects of abuse plus mental health and substance use coercion) are rarely addressed in permanency decisions. This results in effectively punishing and revictimizing survivors and their children for the violence they have endured from an abusive (ex-)partner. Furthermore, substance use during pregnancy, including evidence-based Medication Assisted Treatment (MAT), is considered to be child abuse in 23 states plus Washington DC and 3 consider it grounds for civil

commitment. In addition, 25 states and the District of Columbia require health care professionals to report suspected prenatal drug use, and 8 states require them to test for prenatal drug exposure if they suspect drug use, leading to child welfare system involvement, particularly for low-income women, women of color, and Indigenous women. This serves as a major deterrent to SUD treatment and prenatal care for pregnant and parenting women, placing them at greater risk from an abusive partner and for SUD-related complications and overdose-related death. As states work on the implementation of the Family First Prevention Services Act, we urge the Administration to support programs that incorporate the collaboration between the domestic violence and child welfare systems. We also recommend that the Administration address the impact of substance use and substance use coercion on child welfare system involvement and develop strategies to address policies that disproportionately impact Tribal communities, Two-Spirit/LGBTQ survivors, and communities of color. Such policies should:

a. Support widespread implementation of trauma-informed family-centered services of children in DV programs.
b. Promote resources that support survivors of DV in their interactions with child welfare system.
c. Expand services that support the ability of survivors who are experiencing the mental health and substance use effects of DV, including mental health and substance use coercion, to maintain custody of their children, including increasing access to comprehensive DV- and trauma-informed, gender and culture-responsive, Two-Spirit/LGBTQ-affirming, two-generation substance use, mental health and trauma treatment services, including services for people who are pregnant and parenting;
d. Support research to establish DV-informed Family First treatment modalities and funding a continuum of collaborative/coordinated/Integrated services for SUD, trauma, and DV.
e. Convene an intra-agency workgroup to examine the role of mental health and substance use coercion in child welfare system involvement and develop policy guidance for states.
f. Direct providers and policymakers to resources on these intersections, including curricula for child welfare workers on supporting survivors of DV, resources on creating trauma-informed family-centered DV services, and resources on mental health and substance use coercion.

Recommendation: Prioritize Intimate Partner Violence in Approaches to Improve Maternal and Child Health Outcomes

According to CDC, the leading causes of pregnancy-associated deaths are homicide, suicide, and drug overdose. Intimate partner violence (IPV) during pregnancy has been shown to contribute to maternal mortality from pregnancy-associated deaths. While many studies have addressed clinical conditions related to maternal mortality, there have been fewer studies and less attention paid to deaths from homicide, suicide, and drug overdose and to the relationship between IPV and these types of deaths. A 2016 review of pregnancy-associated deaths in Philadelphia found that 50 percent of the homicides involved intimate partner violence, and 43.7 percent of Black women have experienced physical violence from an intimate partner.[7]

NCDVTMH recommends improvements in research and investments in innovative programs to prevent domestic violence, support survivors and address structural barriers to health equity. Some specific recommendations:

- **Department of Health and Human Services Study:** HHS, in consultation with the Attorney General of the United States, the Director of the Indian Health Service, and stakeholders (including community-based organizations), should study the extent to which individuals are more at risk of maternal mortality or severe maternal morbidity as a result of being a victim of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage. The resulting report include best practices for reducing maternal mortality among IPV survivors and recommended policy or legislative changes to reduce such mortality.

[7] https://pubmed.ncbi.nlm.nih.gov/33295844/

- **Grants for Innovative Approaches:** HHS should do a literature review and field review of innovative approaches that have been developed to improve maternal and child health outcomes of victims of IPV. Following the review, HHS should provide support to test and further evaluate and disseminate these approaches.
- **Health and Human Services Guidance:** HHS should issue and disseminate guidance to States to educate healthcare providers, perinatal health workers, and managed care entities about establishing routine assessment of signs of IPV as well as creating strategies for trauma informed care plans.

Recommendation: Consider Domestic Violence Survivors in Telehealth Policy

As federal policies have changed to encourage telehealth visits during the pandemic, we know that technological abuse is a part of domestic violence Behaviors such as tracking access to technology, monitoring phone and internet usage, attempting to access electronic health records, and location surveillance pose safety, security, and privacy risks to DV survivors and to other household members. DV survivors report consistent challenges to accessing care due to interference by abusive partners (e.g., monitoring or listening-in to sessions, trying to prevent or disrupt participation, threatening the treatment provider,).[1] In addition, domestic violence survivors commonly experience tech abuse from abusive partners. NCDVTMH considers telehealth a valuable care delivery method for improving access to safe and timely services for survivors of domestic violence (DV) who need health, mental health, and substance use care. However, agencies working on telehealth should consider DV survivors as a special population with unique needs. Here are some specific principles and priorities to consider:

- Flexibility is necessary to provide safer access to more comprehensive services;
- Ensure telehealth policy addresses safety, privacy, and confidentiality needs of survivors of DV; and
- Require both technology and process safeguards to protect survivor safety.

A more detailed list of recommendations for these priorities can be found at www.ncdvtmh.org.

Recommendation: Ensure that the National Suicide Prevention Lifeline is equipped to address the unique needs of domestic violence and sexual assault survivors and their children

As SAMHSA invests nearly $300 million in suicide prevention and crisis care services and transitions to a three-digit dialing code (988) from American Rescue Plan, we recommend that collaborations with IPV experts be encouraged through cooperative agreements with FVPSA-funded TA Centers, such as the National Domestic Violence Hotline, NCDVTMH, StrongHearts Native Helpline, etc.

Recommendation: Provide technical assistance to recipients of the SAMHSA Harm Reduction grant program on Intimate Partner Violence

As SAMHSA also invests funding from American Rescue Plan in community harm reduction services and providers, NCDVTMH recommends that domestic violence stakeholders help inform this work focused on preventing overdose deaths and reduce health risks often associated with drug use.

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National Center on Domestic Violence, Trauma, and Mental Health's Approach
For over 20 years, NCDVTMH has enhanced agency- and system-level responses to survivors and their families through comprehensive training and technical assistance, research and evaluation, policy development, and public awareness. Emphasizing an accessible, culturally responsive, and trauma-informed (ACRTI) approach, we offer training and consultation

to domestic violence and sexual assault advocates, programs, and coalitions; healthcare, mental health, and substance use treatment providers; legal and child welfare professionals; and local, state, and federal policymakers.