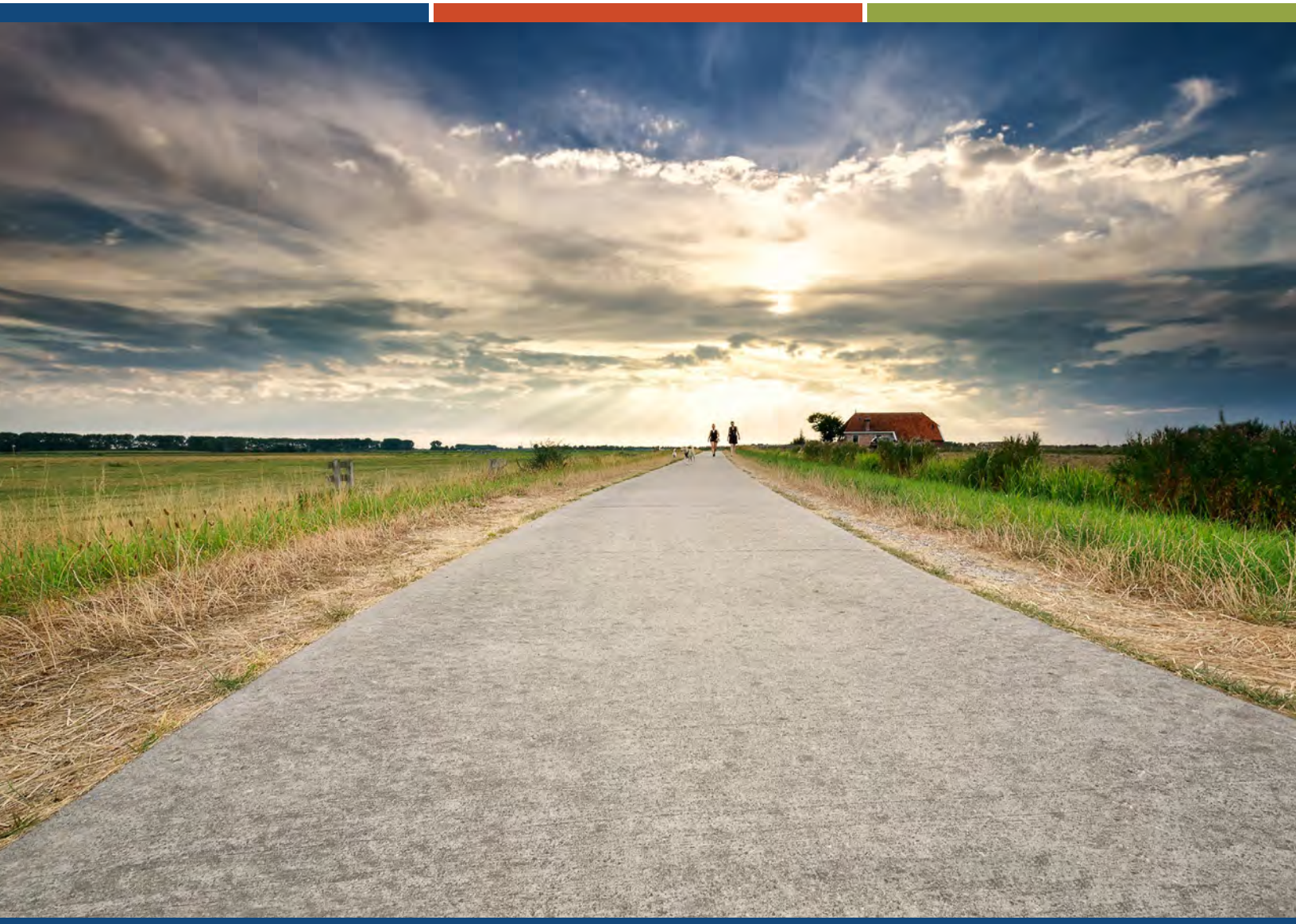


RURAL INTIMATE PARTNER VIOLENCE SURVIVORS AND SUBSTANCE USE DISORDERS: IMPLICATIONS FOR TREATMENT AND RECOVERY SUPPORT PROVIDERS

Mountain Plains ATTC (HHS Region 8)

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

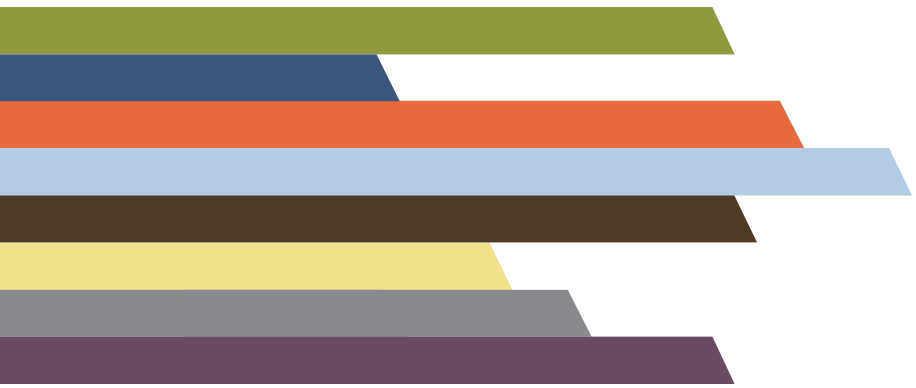


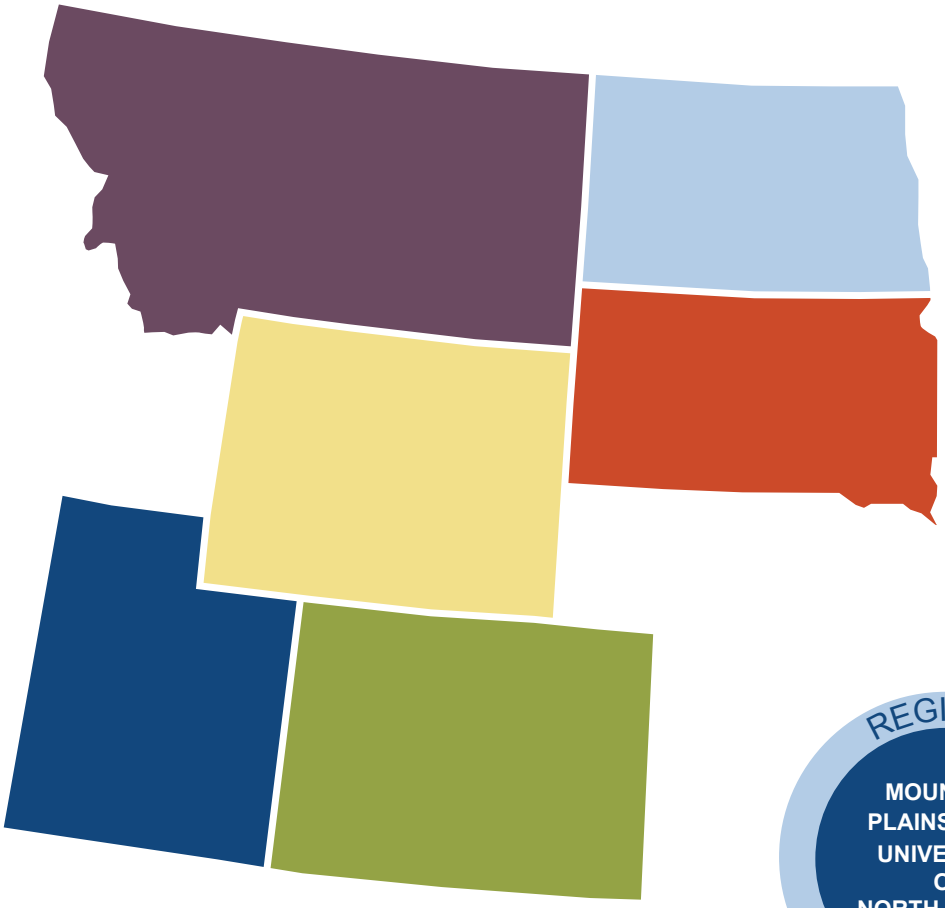
TABLE OF CONTENTS

STATEMENT OF PURPOSE AND AUDIENCE

This product was developed by the Mountain Plains Addiction Technology Transfer Center (ATTC) to serve as a primer for providers of substance use disorder (SUD) treatment services to gain a deeper understanding of the intersection of intimate partner violence (IPV) and SUDs. It provides background information on IPV, describes how IPV and SUDs intersect, suggests how providers may integrate screening for IPV into their practice, provides suggestions for brief intervention, and provides further practice recommendations. While SUD providers will encounter both survivors and perpetrators of IPV in their work with clients, the primary focus of this document is related to survivors. The material underscores the unique dynamics of working with individuals residing in rural areas and presents a case scenario of a woman living in a rural community with recommendations that are based on the limitations of available resources in a rural community. This information will assist SUD treatment providers in their knowledge and skills development on the topic of the convergence of SUD and IPV. In support of that effort we provide the following document to assist treatment providers, specifically SUD treatment and recovery support providers, serving victims/survivors of IPV in rural and remote areas.

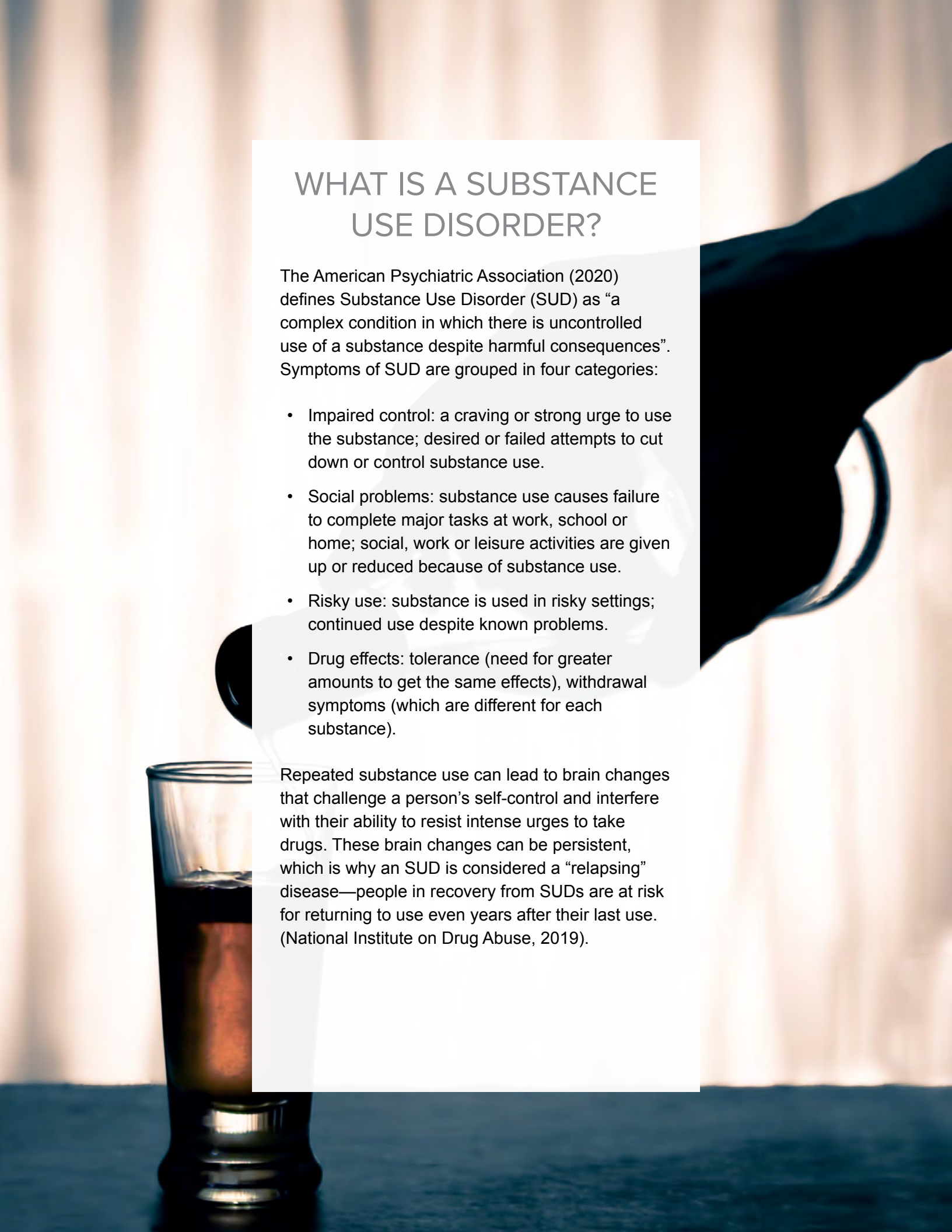
THE MOUNTAIN PLAINS ATTC

The Mountain Plains ATTC, a partnership between the University of North Dakota and the University of Nevada – Reno, and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is tasked with providing training and technical assistance in evidence-based resources for substance use treatment and recovery support providers in HHS Region 8. The Mountain Plains ATTC's goal is to enhance substance use disorder (SUD) treatment and recovery services for individuals and family members, by improving the capacity of the SUD treatment/recovery workforce.



REGION 8

MOUNTAIN PLAINS ATTC
UNIVERSITY OF NORTH DAKOTA



WHAT IS A SUBSTANCE USE DISORDER?

The American Psychiatric Association (2020) defines Substance Use Disorder (SUD) as “a complex condition in which there is uncontrolled use of a substance despite harmful consequences”. Symptoms of SUD are grouped in four categories:

- Impaired control: a craving or strong urge to use the substance; desired or failed attempts to cut down or control substance use.
- Social problems: substance use causes failure to complete major tasks at work, school or home; social, work or leisure activities are given up or reduced because of substance use.
- Risky use: substance is used in risky settings; continued use despite known problems.
- Drug effects: tolerance (need for greater amounts to get the same effects), withdrawal symptoms (which are different for each substance).

Repeated substance use can lead to brain changes that challenge a person’s self-control and interfere with their ability to resist intense urges to take drugs. These brain changes can be persistent, which is why an SUD is considered a “relapsing” disease—people in recovery from SUDs are at risk for returning to use even years after their last use. (National Institute on Drug Abuse, 2019).

WHAT IS INTIMATE PARTNER VIOLENCE?

Intimate partner violence (IPV) is a systematic pattern of learned behaviors that a person uses to control, dominate, or coerce a current or former intimate partner. The behaviors occur over time and are likely to become more frequent and severe. IPV includes physical, psychological, and sexual abuse, stalking, coercion related to mental health and substance use, as well as destruction of property and pets.

A SYSTEMATIC PATTERN

There are several things that are important to note about the definition of IPV. First, IPV is a systematic pattern of behaviors. Many couples argue and may even call each other names or say hurtful things to each other during an argument. IPV, by definition, is not isolated incidents like this. Rather, there is a pattern of behavior that one partner uses, with the purpose of controlling, dominating, or coercing, their current (or former) partner. Without intervention, the pattern is that the abuse almost always increases in intensity, severity, and frequency.

A LEARNED BEHAVIOR

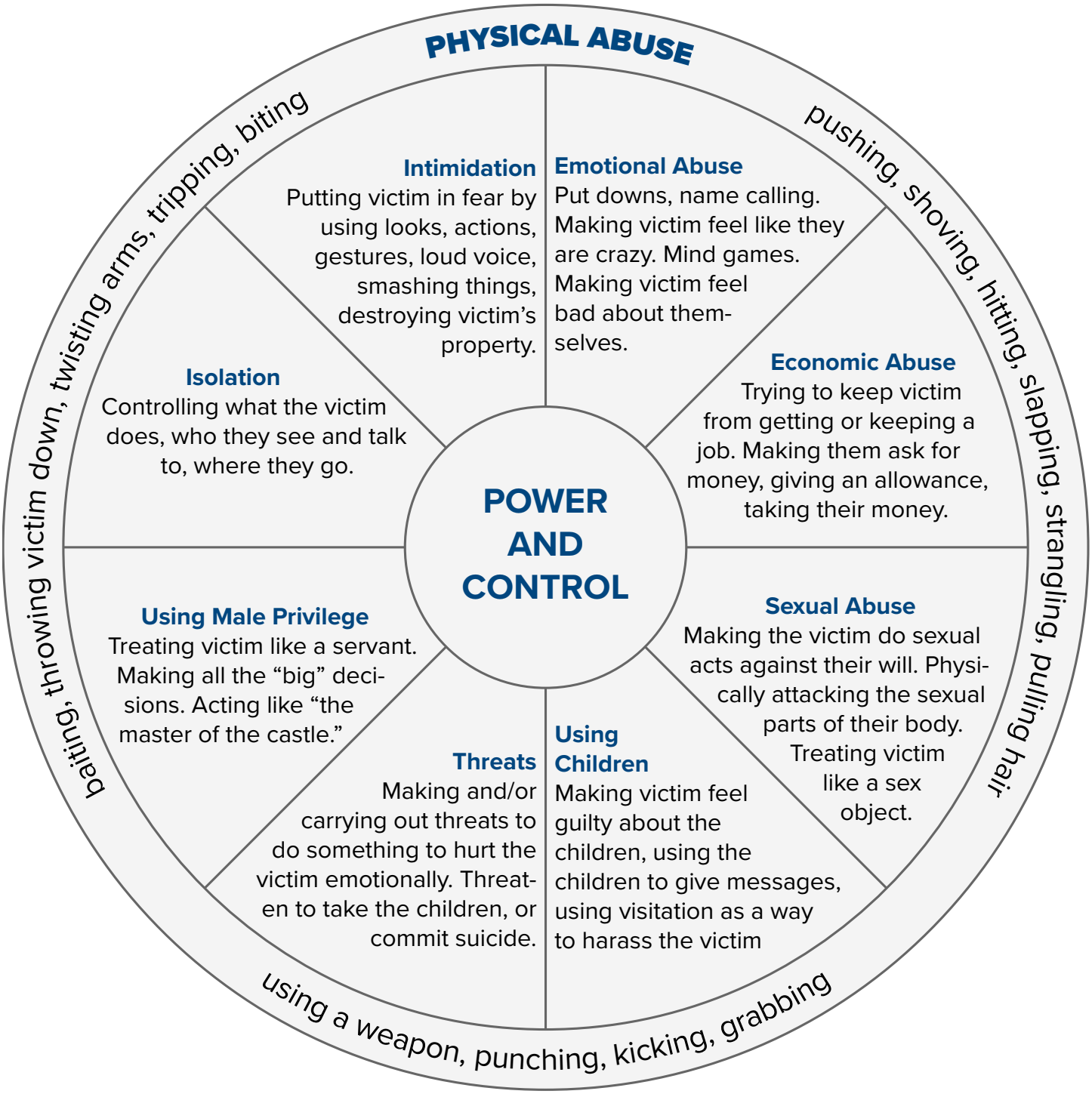
IPV involves learned behaviors. There are many ways in our society that violence and abuse are learned and reinforced: media, video games, cultural and religious groups that promote women in subservient roles, attitudes which ignore or condone abusive behavior, social norms which shape gender norms and ideas about masculinity, and witnessing or being a victim of violence within one's own home as a child. The good news is that if violence can be learned, it can also be unlearned, but it takes a conscious commitment on the part of the perpetrator to acknowledge that their behaviors need to change, and to "unlearn" their behaviors.

UNDERLYING PURPOSE OF BEHAVIORS

Perpetrators use IPV behaviors to control, dominate or coerce a partner. At the root of IPV is power and control. There are many tactics that a perpetrator uses to gain and maintain that power and control over the partner. IPV goes beyond just physical and sexual abuse.

The Power and Control Wheel (see next page) demonstrates that power and control is at the core of IPV, and that there are many different types of physically abusive behaviors (see outer ring) that can be used to gain or maintain that power and control. However, there are also any number of different categories of behaviors that can also be used to control, dominate, or coerce their partner (see spokes of wheel). These behaviors may occur in the presence or absence of the physically abusive behaviors.

THE POWER AND CONTROL WHEEL



WHO ARE VICTIMS/SURVIVORS OF IPV?

We know that IPV disproportionately affects women. Approximately 1 in 4 women and nearly 1 in 10 men have experienced sexual violence, physical violence and/or stalking by an intimate partner in their lifetime and reported some type of related impact (Smith et al., 2018).

It is important to note that when there are reports of males as victims, research consistently demonstrates that IPV survivors use aggression because of their partners' own IPV perpetration. (Rivera et al., 2015). When the pattern of behaviors, with the purpose to control, dominate, and/or coerce are considered, most research indicates that the greatest percentage of victims are women. Therefore, this document will tend to use the terms women/females in relation to victims/survivors. This is NOT to say that men cannot be IPV survivors, and it is NOT meant to minimize the experience of male or LGBTQ survivors. In fact, there is good evidence to show that IPV occurs at least as frequently in LGBTQ relationships as in male-female relationships (National Coalition Against Domestic Violence, 2018), but the largest percentage of IPV is perpetrated by men against women.

WHO ARE PERPETRATORS OF IPV?

Perpetrators of IPV tend to have witnessed violence and/or experienced abuse during childhood. Research indicates that individuals who are exposed to IPV in childhood have up to four times the risk of perpetrating IPV in adulthood, in comparison to those who are not exposed in childhood (Kimber et al., 2018). Further, IPV perpetration rates have been found to be higher for individuals who were victims of child maltreatment, particularly for males (Millet et al., 2013). Other individual risk factors for perpetration of IPV include low self-esteem, low income, heavy alcohol or drug use, antisocial personality traits and conduct problems, impulsivity, emotional dependence and insecurity, and unemployment (CDC, 2020). Thus, it is not uncommon that men who are seeking SUD treatment and recovery services may also be perpetrators of IPV.

1 in 4 Women

1 in 10 Men

Have experienced sexual violence, physical violence and/or stalking by an intimate partner in their lifetime and reported some type of related impact (Smith et al., 2018).

ECONOMIC COSTS OF IPV

IPV results in significant costs to our society. One study found that the cost of IPV in the United States, including health care and productivity losses was estimated to be $9.3 billion in 2017 dollars (McLean & Bocinski, 2017).

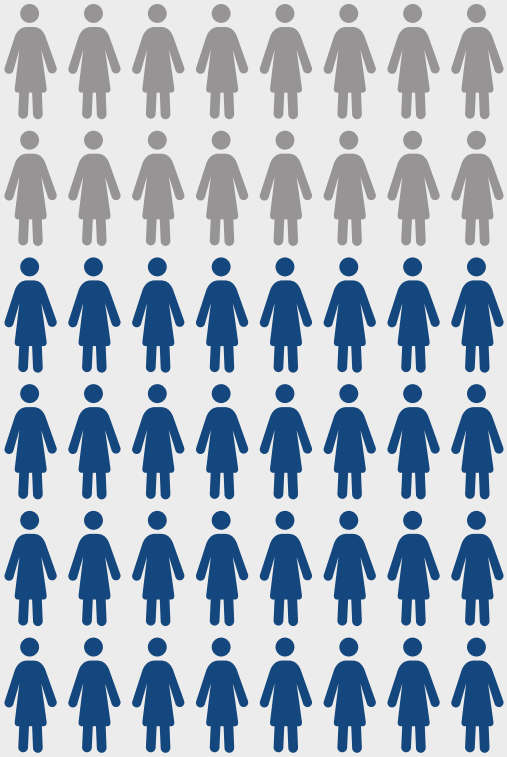
Additionally, the lifetime per-survivor cost of IPV is $103,767 with 59% of those dollars going to health care costs (Centers for Disease Control and Prevention [CDC], 2018)

PHYSICAL AND SEXUAL/REPRODUCTIVE HEALTH CONSEQUENCES OF IPV

The World Health Organization (2012) reports multiple effects of IPV on the health of survivors, some of which may be immediate and some of which may become chronic, persist long after the violence has stopped, or may even be fatal. The health consequences tend to be cumulative over time and more severe when a woman experiences more than one type of abuse (e.g. physical, sexual, psychological). Table 1 summarizes the physical and sexual/reproductive health consequences of experiencing IPV.

Table 1. Physical and Sexual/Reproductive Health Effects of IPV (World Health Organization, 2012)

Physical	Sexual/Reproductive
• Acute or immediate physical injuries, such as bruises, abrasions, lacerations, punctures, burns and bites, as well as fractures and broken bones or teeth • More serious injuries, which can lead to disabilities; these might include injuries to the head (including traumatic brain injuries), eyes, ears, chest and abdomen • Gastrointestinal conditions, long-term health problems and poor health status, including chronic pain syndromes • Death, including femicide (purposeful killing of a woman by her intimate partner) and AIDS-related death	• Lower rates of contraceptive and condom use • Unintended/unwanted pregnancy • Abortion/unsafe abortion • Sexually transmitted infections, including HIV • Pregnancy complications and miscarriage • Vaginal bleeding or infections • Chronic pelvic infection • Urinary tract infections • Fistula (a tear between the vagina and bladder, rectum, or both) • Painful sexual intercourse • Sexual dysfunction



67% of Women

Who Experience IPV

Report feeling fearful and concerned for their safety

MENTAL HEALTH AND IPV SURVIVORS

Living with the stress of IPV takes a toll not only physically but mentally as well, resulting in increased threats to mental health among survivors. Up to 67% of women who experience IPV have reported regularly feeling fearful and concerned for their safety (CDC, 2010). IPV survivors have three times the risk of developing a major depressive disorder, when compared with women who have not experienced IPV (Beydoun et al., 2012). Further, the risk of post-traumatic stress disorder (PTSD) may be three times higher in women who have experienced IPV than those who have not (Beydoun et al., 2012), and research indicates that between 31% to 84% of IPV survivors meet the criteria for PTSD (Woods, 2005). In relation to serious mental illness (SMI), the best estimates suggest the rate of IPV among women with SMI is between 22% to 76%. Women with SMI are at greater risk of continued victimization, and in turn, victimization exacerbates symptom severity (Van Deinse et al., 2018). The World Health Organization (2012) also identifies poor self-esteem and eating and sleeping disorders as mental health consequences of IPV. Most concerning, women who have experienced IPV have higher rates of suicide attempts and suicide ideation than women who have not been victimized by an intimate partner (Warshaw et al., 2018).

THE CO-OCCURRENCE OF IPV AND SUDs AMONG SURVIVORS

It is common for IPV and substance use disorders (SUDs) to occur together. However, it is important to understand that while the two conditions often co-exist and are associated with each other, it does not mean that one causes the other. Recall that the motivating factor behind IPV is coercion, power and control over another, and that can happen in the presence or absence of substances or SUDs.

In a review of research studies with survivors of IPV, the prevalence of substance use or abuse was found to be anywhere from 18-72%. The wide variation in prevalence rates are largely because of how IPV and substance use/abuse is defined, and in what populations are studied. But overall, across studies, the prevalence is consistently higher among IPV survivors when compared to women who are not in relationships with IPV, with studies reporting anywhere between two to nine times higher likelihood of substance use/abuse (Rivera et al., 2015).

When we examine IPV among persons with SUDs, the rates of both IPV within the past year and over the lifetime are considerably higher than rates from national studies with the general population. Studies show that somewhere between 31% to 67% of women in SUD treatment settings report experiencing IPV during the past year, and 47% to 90% report experiencing IPV during their lifetime (Rivera et al., 2015). Those rates again vary from study to study, based upon definitions and populations studied, but regardless, the rates indicate that IPV and SUDs commonly co-occur.

A BI-DIRECTIONAL RELATIONSHIP

When we understand that there is a relationship between IPV and SUDs, the question often is asked: Which comes first—IPV or SUDs? Research with survivors tells us that it is a bidirectional relationship (it goes both ways). In some cases, SUDs may precede IPV, while in other cases, IPV preceded SUDs (Rivera et al., 2015).

First, the use of substances may be associated with increased risk of victimization. Saying this in no way implies that women who use substances are to blame for their IPV victimization. The perpetrator is still the one responsible for the IPV. However, the use of substances may make women easier to “control” and the effects of the substances may prevent a woman from accurately assessing the level of danger that she may be in with a partner. Further, the use of substances can cause problems with memory, which may in turn, cause a woman to question the reality of what occurred. When this is accompanied by the perpetrator distorting the facts of what occurred or telling her the abuse is her fault, the survivor may have difficulty discerning the actual danger the relationship poses to her (Rivera et al., 2015).

At the other end of the relationship, IPV may precede SUDs. Survivors of IPV may begin using substances as a way to cope with the traumatic effects of IPV. Certainly, the psychological effects may cause IPV survivors to try to self-medicate their mental health symptoms with substances. Survivors also are likely to experience acute and chronic pain because of the violence.

31% to 67%

Of women in SUD treatment settings report experiencing IPV during the past year

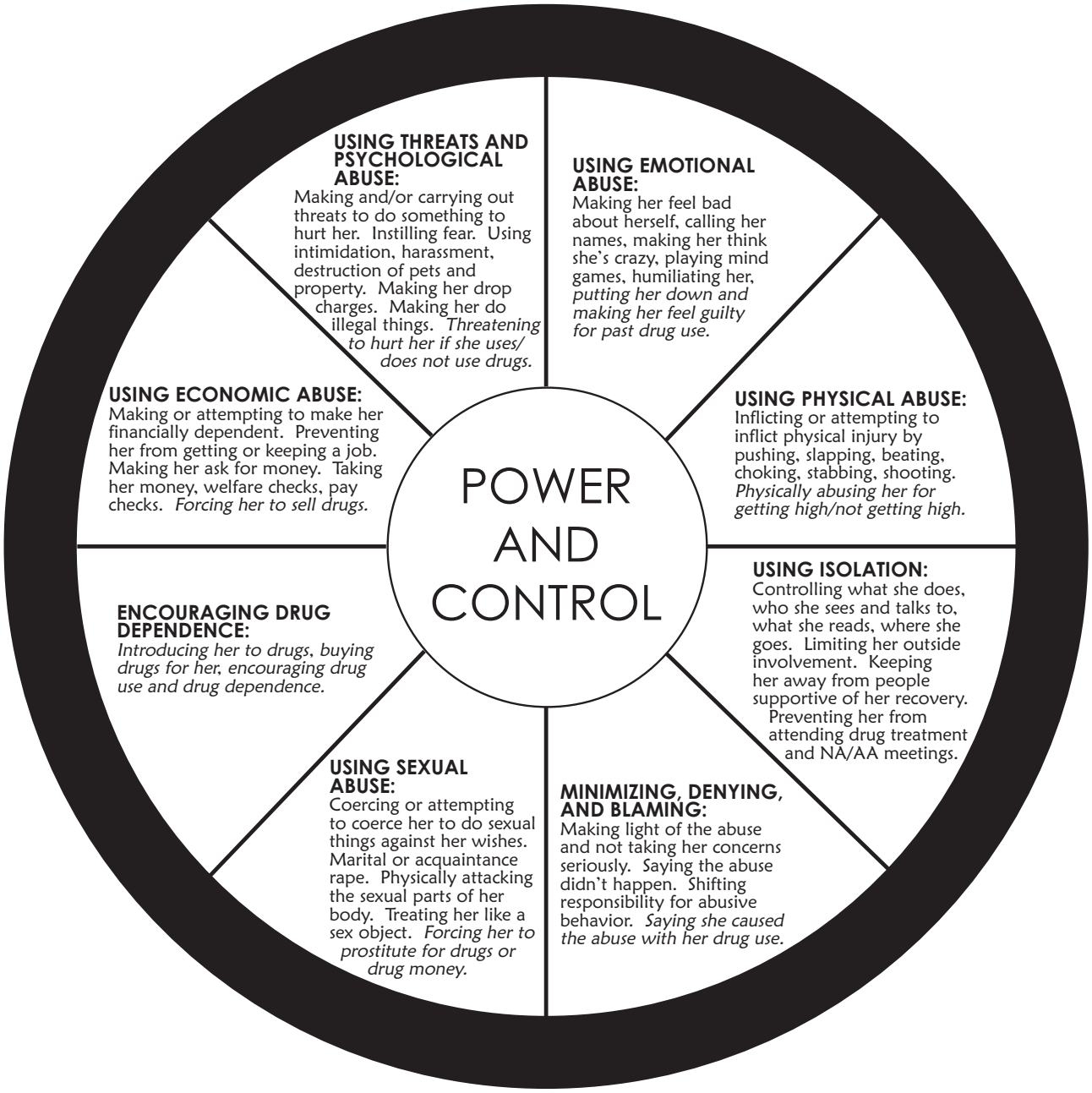
47% to 90%

Report experiencing IPV during their lifetime

As a result of chronic pain caused by violence, survivors may be prescribed opioids leading to subsequent SUDs. It is also likely that survivors who do not have access to medical care (either because they are prevented from going or have no health insurance), may use alcohol or non-prescription medications to try to deal with their pain (Phillips et al., 2019).

Substance use can also be used as a method of control and coercion over a partner. Perpetrators may have a role in survivors initiating use of substances as a way to gain control and then maintain power and control in the relationship. Women have been known to be coerced by their partners to use alcohol or drugs for the first time. Sometimes this occurs through coercive tactics such as telling her “if you really loved me, you would drink with me,” or “this will bring us closer together”. At other times, the coercion can actually occur by force. Coercive tactics can also include efforts to intentionally undermine their partner’s attempts to seek SUD treatment, interference with their treatment, control of their medication, sabotaging their recovery, and discrediting them with friends, family, professionals, and the courts (Warshaw & Tinnon, 2018). These methods of coercion and control need to be considered in relation to other methods used to gain and maintain power and control over the woman. A multitude of coercion tactics can be used to maintain their dominance, some can be seen in the Power and Control Wheel for Women with SUDs (see next page).

Power and Control Model for Women's Substance Abuse



Adapted from:
Domestic Abuse Intervention Project
202 East Superior Street
Duluth, MN 55802
218.722.4134

Excerpted from:
"Safety and sobriety: best practices in domestic violence and substance abuse," p. 66, Domestic Violence/Substance Abuse Interdisciplinary Task Force, Illinois Department of Human Services.

Produced and distributed by:

NATIONAL CENTER
on Domestic and Sexual Violence
training · consulting · advocacy
4612 Shoal Creek Blvd. · Austin, Texas 78756
512.407.9020 (phone and fax) · www.ncdsv.org

CONSEQUENCES FOR IPV SURVIVORS WITH SUDs

The stigma associated with SUDs is well known, as is the stigma associated with IPV. When a survivor lives with both, the stigma is compounded. IPV survivors often find that their credibility is in doubt, and when they have either a history of SUD and/or mental health issues, survivors will have an even higher level of doubt placed upon them (Warshaw & White-Domain, 2014). A survivor may be perceived as "an addict" or "a drunk" (these terms are used here as an example of how an individual with an SUD is stigmatized using pejorative language) and so it becomes easy to blame the victims. Others may convey that she put herself into the situation and that "if she just got sober, this wouldn't keep happening". This type of stigma and bias wrongly places the onus of responsibility on the survivor rather than the perpetrator. An excellent resource for more information on stigma and SUDs, including pregnant and parenting women, is a HealtheKnowledge course at: https://attcnetwork.org/centers/mountain-plains-attc/addressing-stigma-and-substance-use-disorders-healtheknowledge-course. Additionally, the ATTC's Language Matters: Using Affirmative Language to Inspire Hope and Advance Recovery document provides language for reducing the stigma of SUDs: https://attcnetwork.org/sites/default/files/5-Language_Matters_9-18-17.pdf.

The stigma experienced by IPV survivors with an SUD may result in a fear of seeking help outside of the home, including treatment and recovery support services. Additionally, perpetrators may prevent a survivor from seeking or obtaining services. In a study of callers to the National Domestic Violence Hotline, approximately 15% of callers had attempted to seek help for substance abuse. Of those, 60% reported their partner had prevented or discouraged such treatment (Warshaw, et al., 2014). Additionally, 24% of callers reported that they were afraid to call the police because their partner convinced them they would not be believed or that they would be arrested because of their substance use (Warshaw et al., 2014). For women with children, the fear of losing custody because of their substance abuse is often a driving factor in them staying with an abusive partner or not seeking help from outside sources.

IPV AND CHILDREN

Families where IPV/SUD is occurring are frequently concerned about reports to the child welfare system for assessment and treatment and a negative outcome. Mandatory reporting laws that exist in all states require professionals to report suspected abuse and neglect. A summary of all the laws for all states and U.S. territories are included here https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/. Of note, exposure to IPV for children includes hearing, witnessing, and intervening during an incident as well as witnessing the impact on the mother after the incident (Kitzmann et al., 2003). However, whether or not exposure to IPV is required to be reported varies from state to state. One out of four (25%) 14 to 17-year olds have witnessed a parent assault another parent in their lifetime (Finkelhor et al., 2015). This underscores the need for a child welfare system of care, in assessing cases where IPV is present, to recognize the effect of trauma on functioning and recovery among family members (Substance Abuse and Mental Health Resources Administration [SAMHSA], 2014) and supports for effective interventions. Implementation of trauma-informed care and critical attention to the importance of safety and reduction of possible re-traumatization of clients is paramount and noted by Children's Bureau and SAMHSA.

Casey Family Programs provides a review of the impact of mandatory reporting laws on help seeking among survivors of intimate partner violence. Their research found that 35% of the respondents (victims of IPV) did not ask for help from at least one person because of mandatory reporting laws, and survivors fear the child protection services will remove their children (Lippy et al., 2019). This underscores the need for a cross training on SUD/IPV and child welfare systems of care, given the depth and breadth of this concern.

The National Child Traumatic Stress Network provides resources to assist providers who serve children who live in homes with domestic violence describing trauma types including trauma treatment, trauma-informed care, and resources (National Child Traumatic Stress Network, 2021). A host of factors influence the lives of children when they are living in homes where domestic violence occurs including: (1) how serious was the violence or threats, (2) what is the child's relationship with the victims of the abuser, (3) what is the child's relationship with the abuser, (4) was the child physically harmed or put in danger, (5) what is the age of the child, (6) what additional stressors exist in the child's life, (7) what positive activities are in the child's life, and (8) what are the child's coping abilities.

Research supports the long-term implications of exposure to violence that includes lack of adequate coping and problem-solving skills and problems with managing stressors including exacerbating the risk for suicide (Kimball & Keene, 2016). The Substance Abuse and Mental Health Services Administration (2015) provides a Quick Guide for Clinicians based on TIP 25 entitled Substance Abuse Treatment and Domestic Violence that has valuable content for clinicians including screening for survivors, screening techniques, questions for batterers, treatment planning for batterers, referrals, and legal issues. An updated appendix provides content for consideration for intimate partner violence and child abuse considerations during COVID-19 (SAMHSA, 2021).

SUDs AMONG PERPETRATORS OF IPV

Most research in relation to IPV and SUDs examines this relationship among survivors; the relationship with perpetrators is not as well-studied (Rivera et al., 2015). However, some studies have indicated that once the perpetrator's substance use was considered, women's substance use was no longer associated with any significant risk of victimization (Rivera et al., 2015). In other words, if a study only measures the victim's substance use, and doesn't account for the perpetrator's use, it will look like the victim's use is the associating factor; but when both are measured, it is the perpetrator's use that actually accounts for the greatest risk of victimization.

One large national study found that alcohol use disorders and cocaine dependence were most strongly associated with IPV perpetration (Smith et al., 2012). However, regardless of the substance used, the relationship between SUDs and perpetration of IPV is strongest for those men who think IPV is appropriate in certain situations. A common misunderstanding is that perpetrators are extremely intoxicated or are out of control when they engage in IPV. Perpetration of IPV is a matter of choice. The fact that IPV usually occurs in a setting that is safe for the perpetrator (not usually in a public setting), and is within a perpetrator's comfort zone, suggests that he is very much in control. Further, IPV often continues even when a perpetrator receives SUD treatment and is in recovery. It is very important to remember that a majority of those with SUDs are never perpetrators of IPV (Bennet & Bland, 2008).

IPV IN RURAL AREAS

The rates of IPV have been found to be generally similar across rural, urban, and suburban locations. However, some types of IPV (for example sexual IPV and IPV that is perpetrated by a spouse or ex-spouse) and femicide (death of a woman by her intimate partner) may be higher in rural locations than non-rural (Edwards, 2015). Further, IPV perpetrators in rural locations have been found to commit violence which is more chronic and severe (Edwards, 2015; Peek-Asa et al., 2011). One study (Favor and Strand, 2003) even found that rural perpetrators were more likely than urban perpetrators to threaten or actually harm IPV survivors' pets. While many factors related to IPV are similar across locations, IPV in rural areas has several unique issues which should be understood among those providing services to IPV survivors from rural locations.

Information about co-occurring SUDs and mental health concerns in rural areas is provided in a document produced by the Mountain Plains ATTC & Mountain Plains MHTTC, and can be found at: https://attcnetwork.org/sites/default/files/2020-04/ATTC-MHTTC-FarmStress-Brochure-Interactive.pdf

SOCIAL ISOLATION

By virtue of the geographic location of rural communities, IPV survivors experience social isolation. Recall that isolation from others is a major tactic that perpetrators use to dominate and control their partner. Thus, living in a rural area may make it easier for IPV to occur, and may contribute to the increased severity and frequency of violence (Peek-Asa et al., 2011).

The mere fact that the nearest neighbor may be miles away may make it easier for the violence to go undetected and unreported.

The lack of proximity to neighbors may also make it more difficult for IPV survivors to develop close relationships with others in whom they can confide or seek social support (Dudgeon & Evanson, 2014). The isolation may also seclude IPV survivors from services, which can contribute to a high frequency and chronicity of the violence because of lack of intervention (Peek-Asa et al., 2011).

PATRIARCHAL BELIEFS AND TRADITIONAL GENDER ROLES

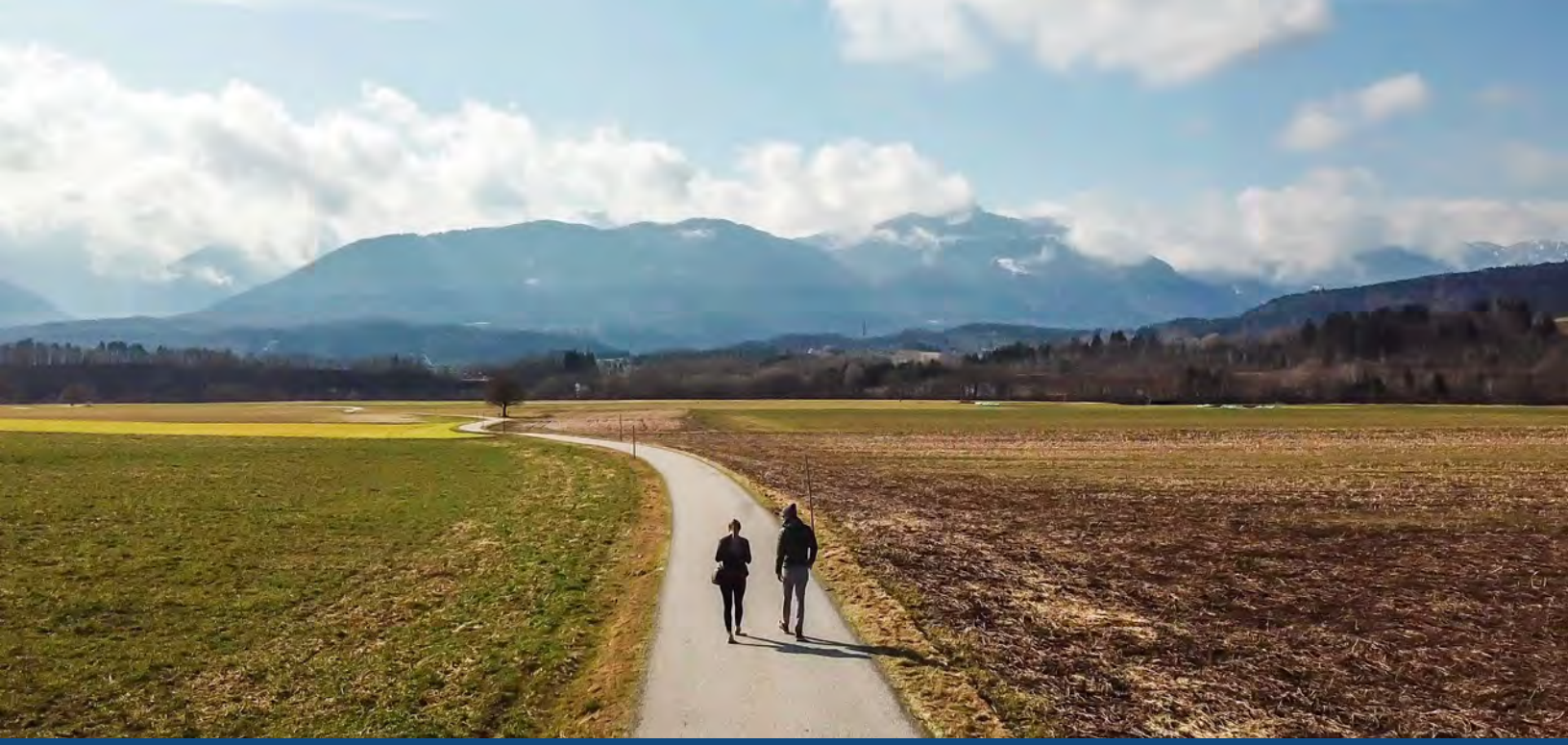
Rural survivors of IPV may be more vulnerable because of traditional rural values and beliefs about gender roles, which favor male dominance. One study on rural IPV found that, "patriarchal views of the family and the role of women, the permanence of marriage, religious convictions, and rural cultural norms pose challenges for providing community resources in rural areas" (Riddell et al., 2009). Further, rural women have reported that a common belief in their communities was what happens between a man and a woman is a private matter (Riddell et al., 2009). These attitudes toward IPV may contribute to rural survivors' ***feelings of shame and self-blame,*** which may in turn ***hinder help-seeking,*** driving the survivor into further isolation (Dudgeon & Evanson, 2014).

RELIGIOUS BELIEFS

Churches tend to be the center of rural communities, and rural residents have a higher degree of religiosity (Bushy, 2006) and are generally more conservative and "churchgoing" Christians (Bushy, 2020). This may influence one's beliefs and help-seeking behaviors (Bushy, 2020). Some literal interpretations of religious teachings support that women must serve and obey their husbands at all costs. A survivor that believes divorce is a sin may not view leaving her husband as an option. Many rural residents rely upon local clergy for counseling for IPV, SUDs, and mental health conditions. However, research has shown that the ability of members of the clergy to provide effective counsel for IPV varies greatly (Lewy & Dull, 2005). The manipulation of religious beliefs, teachings, and scripture may even become a way to coerce or control a partner (Bent-Goodley & Fowler, 2006).

TIES TO THE LAND

Rural community members often have a strong emotional bond with the land and with their communities. In farming communities, the family farm may have been in the survivor's family for generations. For many rural IPV survivors, leaving the farm for safety may be a highly difficult and



emotional situation. In doing so, survivors may feel they have let their extended family down. ***Further, leaving the family farm means not only leaving their home, but also their place of business and economic investment.*** Moving to an area where counseling/treatment services and education and employment opportunities are more available may be a difficult consideration for IPV survivors (Faller et al., 2018).

EMPLOYMENT AND ECONOMIC FACTORS

Demographically, rural populations have higher rates of poverty, lower average incomes, and fewer employment opportunities, when compared to non-rural populations (Crosby et al., 2012). These sociodemographic factors have all been found to be risk factors for perpetration of IPV (Beyer et al., 2015). Additionally, with these conditions existing in rural areas, there are often fewer resources for survivors to be economically independent of their partner (National Advisory Committee on Rural Health and Human Services, 2015). Further, the stigma related to IPV, mental illness and SUDs may prevent survivors from being able to obtain employment within their own communities (Bender, 2016).

It is also important to note that unemployment among abusive men has been found to be the greatest sociodemographic factor associated with femicide (Campbell et al., 2003).

CONCERNS FOR PRIVACY, CONFIDENTIALITY, AND ANONYMITY

In rural communities, where "everybody knows everybody", the fears of loss of confidentiality, privacy, and anonymity may prevent women from seeking care and treatment for SUDs, mental health and IPV. For example, IPV survivors or perpetrators may have personal relationships with members of the police, physicians, judges, or SUD treatment providers.

Locations of shelters or safe houses may be common knowledge, and a survivor's vehicle may be easily identifiable when seeking services.

All of these factors, combined with the stigma of IPV, SUDs and/or mental illness may inhibit survivors from seeking help, even when significant injuries may have occurred (Bender, 2016).

LAW ENFORCEMENT FACTORS

Rural areas tend to have smaller law enforcement units, largely because the size of a unit is based upon population size and does not account for level of crimes or geographic distance to be covered (Hansen & Lory, 2020). Thus, in rural areas, ***there are fewer officers spread out over large geographical distances,*** often resulting in longer response times, which may be up to one hour or longer (Hansen & Lory, 2020), and may act as a deterrent to IPV survivors seeking help (Faller et al., 2018). As previously mentioned, IPV survivors may also be reluctant to contact law enforcement due to possible personal relationships, stigma and confidentiality concerns.

Firearms are common in rural homes and may result in increased lethality for IPV survivors. In fact, the presence of a firearm in the home is the greatest overall risk factor for femicide (Campbell et al., 2003). It is has also been found that restraining/

protection orders may be less effective in rural communities (Vittes & Sorenson, 2008; Hansen & Lory, 2020). In a study of restraining/protection orders among women who were victims of femicide, there were actually more rural women who had an order than urban women (Vittes & Sorenson, 2008). It may be difficult for law enforcement to enforce a restraining order among farmers/ranchers, as the partner may need to tend the land or the livestock on the land on which the victim is living (Hansen & Lory, 2020).

When looking at arrests for IPV perpetration, a systematic review of the literature (Edwards, 2015) found that compared with urban male arrestees, rural male arrestees demonstrated:

- lower employment rates
- lower educational attainment
- greater use of psychoactive medications
- greater use of a combination of psychoactive drug and alcohol use
- more prior and post IPV arrests
- a greater likelihood to have been court ordered to marital therapy
- a lower likelihood to have been court ordered to anger management therapy

Further, they reported that urban law enforcement may be more likely to remove the perpetrator from the home than rural law enforcement. While law enforcement is responsible for dealing with the perpetrator, in rural areas they may have limited resources and authority to help IPV survivors. Thus, their ability to effectively provide aid to women and children who may be at risk may be reduced (Faller et al., 2018).

ACCESS TO SERVICES

Due to an overall lack of health and human services located in rural and isolated communities, rural IPV survivors' ability to access services to address IPV, SUDs, mental and physical health concerns is limited. Low populations, coupled with higher rates of poverty and unemployment result in a lower tax base to support publicly funded programs and services (Cook-Craig et al., 2010). Further, lower incomes and higher rates of being uninsured, make it more difficult for individuals to seek care from the services that are available (Bender, 2016). All of this results in less available, acceptable, and accessible services for rural IPV survivors.

Rural survivors of IPV may not be able to access SUD treatment services until court-ordered to do so (Bender, 2016).

In one study (Peek-Asa et al., 2011), the average distance to the nearest IPV services was three times greater for rural women than for urban women, and rural IPV programs served more counties and had fewer on-site shelter services. Additionally, over 25% of rural women lived more than 40 miles from the closest IPV program. Rural communities generally lack public transportation services that would allow an IPV survivor to be able to access services at this distance. Thus, it is possible that IPV survivors in rural locations may have worse behavioral and physical health outcomes due to the lack of services and/or difficulty accessing services that are available or acceptable (Edwards, 2015).

Additionally, it should be noted that rural health and human service providers often serve a diverse population, which is reflective of many rural areas. Limited research has been conducted on the experiences and needs of women of color who experience IPV in rural America (National Advisory Committee on Rural Health and Human Services, 2015). Women of color living in rural communities are often faced with the additional challenge of finding services and interventions relevant to their own cultures (Faller et al. 2018). In one study on rural IPV in North Dakota, South Dakota, and Minnesota, it was noted that the service provider population was almost entirely white, while the clientele came from diverse backgrounds. The authors also noted a need for more diverse staff and multicultural training to enhance communication between providers and women of color (Semler et al., 2010). The critical need for women who experience SUDs and IPV is for providers to respond in a culturally responsive manner.

The ATTC Network provides numerous resources related to diversity and inclusion in practice, which can be accessed at: https://attcnetwork.org/centers/global-attc/clas-resources.

RURAL SERVICE PROVIDER ISSUES

Isolation in rural areas pertains not only to IPV survivors; service providers can be isolated and lack professional support and continuing education opportunities as well (Cook-Craig et al., 2010). Rural service providers often face high staff turnover rates, overworked existing positions, volunteer burnout, and inadequate training (Faller et al., 2018). Rural communities also struggle with providing adequate institutional support services necessary to meet the needs of their populations. As noted, many health and human service agencies rely on population-based funding structures, which ensure less funds in rural communities than areas with higher populations, regardless of the magnitude of the problems they face (Cook-Craig et al., 2010).

It may also be difficult for rural providers to have evidence-based fidelity to IPV and behavioral health interventions and programs, due to a lack of evaluation research in rural and remote areas.

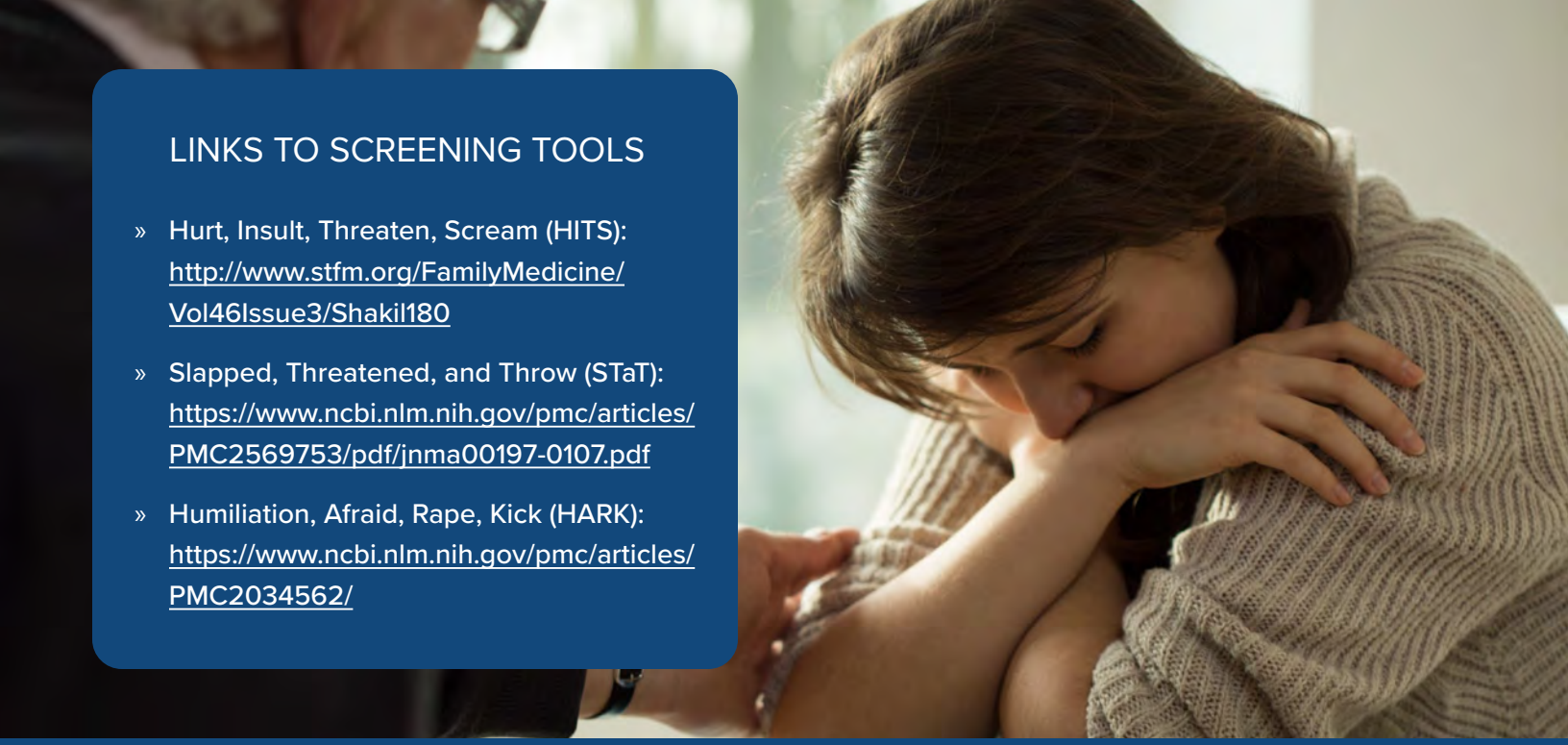
Rural agencies and providers may be in the position of having to determine if a particular evidence-based intervention will even work in their rural program, because it usually hasn't been tested in rural populations (Cook-Craig et al., 2010).

IPV survivors have reported experiencing little collaboration or communication across agencies (Van Deinse et al., 2018). While this is not unique to rural settings, the lack of collaboration and communication may be exacerbated among rural providers because of distance between agencies, lack of familiarity with providers not within the local community, rural concerns about confidentiality, and lack of recommended best practices for coordination among rural IPV and behavioral health providers.

SCREENING FOR IPV IN THE SUD SERVICES SETTING

It is important for SUD treatment/recovery providers to ask all clients about IPV victimization, because IPV is so common among persons with SUDs and the tactics used to maintain power and control are likely to sabotage an individual client's recovery. Providers are often nervous or fearful about asking about IPV, but asking creates an opportunity for survivors to disclose abuse, which in turn gives providers the opportunity to provide support, information, and referrals to appropriate resources.

Addressing the topic of IPV should only be done with clients individually, in private. It is helpful to normalize the questions, by acknowledging that abuse is a common issue in many women's lives. For example, the SUD provider might say: "Because we know that violence is so common among our clients, we ask everyone about it, as part of our routine assessment" (Dudgeon & Evanson, 2014). Screening questions should ask directly about specific types of abuse. Questions such as "Do you feel safe in your home?" are not generally helpful in identifying IPV, because the idea of "being safe in your home" can be interpreted in many ways. The U.S. Preventive Services Taskforce (2018) has recommended a number of screening tools including Hurt, Insult, Threaten, Scream (HITS) (Available in English and Spanish) (Shakil et al., 2014); Slapped, Threatened, and Throw (STaT) (Paranjape et al., 2006); and Humiliation, Afraid, Rape, Kick (HARK) (Sohal et al., 2007). All three of these tools are brief (three to four questions), easy to use, and demonstrate good sensitivity and specificity.



LINKS TO SCREENING TOOLS

- Hurt, Insult, Threaten, Scream (HITS): http://www.stfm.org/FamilyMedicine/Vol46Issue3/Shakil180
- Slapped, Threatened, and Throw (STaT): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569753/pdf/jnma00197-0107.pdf
- Humiliation, Afraid, Rape, Kick (HARK): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/

In addition to use of standard screening questions, it may be particularly helpful in the SUD treatment/recovery setting to include questions about the connection between a person's relationship with their partner and their mental health and/or use of substances. This creates an opportunity for someone who is experiencing IPV to think about how these issues might be connected for them (Warshaw & Tinnon, 2018). For example, in your SUD assessment, you might say, "Sometimes women increase their use of drugs/alcohol because they feel isolated or trapped in a relationship, or because they are living in fear from their partner. Is there any connection in those things for you?" If a woman does indicate that their substance use may be related to such indicators of IPV, it is also helpful to ask about coercive behaviors in order to fully understand potential barriers she may face in her treatment and recovery. For example, "How does your partner treat you when you are using? When you are not using? Does your partner ever use your substance use, or your partner's substance use, as justification for being hurtful to you?" For in-depth information about substance use coercion in relation to IPV, we recommend a toolkit for screening, assessment, and brief counseling, by Warshaw & Tinnon (2018), available through the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) at: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2018/03/NCDVTMH_MHSUCoercionToolkit2018.pdf.

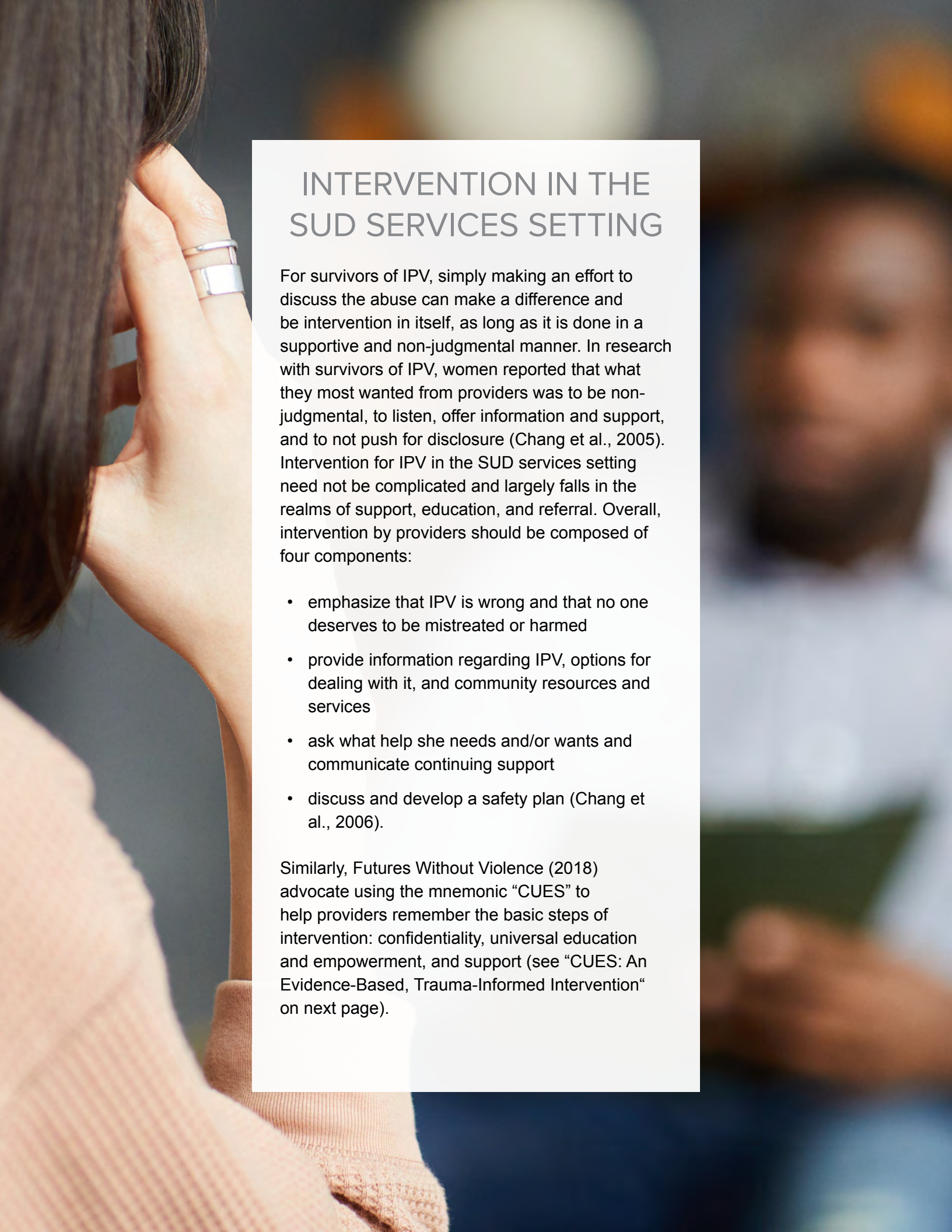
It is important to keep in mind that even when IPV is suspected, a survivor may or may not disclose that it is occurring. Survivors of IPV know when it is safe for them to disclose and when it is not. That decision needs to be honored. However, even in cases where IPV is suspected, but the client answers "No" to all screening questions, it is still possible to provide intervention (see Intervention section below), and then revisit the issue as your relationship builds.

CONFIDENTIALITY RELATED ISSUES

Prior to approaching the subject of IPV and asking screening questions, you need to have a discussion about confidentiality and the limits of that confidentiality. While a client should be assured that you will hold the discussion in confidence, you also need to explain that you are a mandated reporter for child maltreatment, and depending on which state you are practicing in, there may be mandatory reporting requirements for IPV as well. https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/. The reporting laws throughout the United States and territories restrict the privilege of confidentiality for mandated reporters of child abuse and neglect. While this varies from state to state, it is important that providers are informed about the requirement of their license. An excellent reference which describes the state and tribal statutes and policies on domestic violence, as well as which disciplines are required to report IPV, can be found on the Futures Without Violence website at: https://www.futureswithoutviolence.org/compendium-of-state-statutes-and-policies-on-domestic-violence-and-health-care/.

The United States Health and Human Service (HHS) Children's Bureau provides a factsheet that discusses laws that impose penalties in the form of fines, jail time, or both, on mandatory reporters who fail to report cases of suspected child abuse and neglect as required by the reporting laws.

https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/. Since IPV perpetrators often try to use drug/alcohol coercion as a means to control their partner, and use tactics to sabotage their treatment/recovery, confidentiality from her partner or other family members is important. SUD service providers should also explain that if IPV is an issue for the client, she may not want to sign a consent for the release of information for her partner or she can limit the disclosable information if she feels it is safe to disclose any level of information. Most SUD treatment providers follow the Federal Confidentiality Rules and Regulations 42 CFR Part 2 and HIPAA. With 42 CFR Part 2 consent for the release of information requires providers to list the specific information to be released. The child welfare worker in situations where reports of IPV has been reported must be aware of the importance of protecting the safety of the children and the victim while conducting an assessment.



INTERVENTION IN THE SUD SERVICES SETTING

For survivors of IPV, simply making an effort to discuss the abuse can make a difference and be intervention in itself, as long as it is done in a supportive and non-judgmental manner. In research with survivors of IPV, women reported that what they most wanted from providers was to be non-judgmental, to listen, offer information and support, and to not push for disclosure (Chang et al., 2005). Intervention for IPV in the SUD services setting need not be complicated and largely falls in the realms of support, education, and referral. Overall, intervention by providers should be composed of four components:

- emphasize that IPV is wrong and that no one deserves to be mistreated or harmed
- provide information regarding IPV, options for dealing with it, and community resources and services
- ask what help she needs and/or wants and communicate continuing support
- discuss and develop a safety plan (Chang et al., 2006).

Similarly, Futures Without Violence (2018) advocate using the mnemonic “CUES” to help providers remember the basic steps of intervention: confidentiality, universal education and empowerment, and support (see “CUES: An Evidence-Based, Trauma-Informed Intervention“ on next page).

VALIDATION

Even if a survivor is not ready to leave a violent relationship, recognition and validation of their situation is important (Miller & Glass, 2018). If a client discloses IPV, it is important to validate that the abuse is not her fault and no one deserves to have a partner who is controlling, dominating, and/or coercing them. It will be helpful to validate that "It is never your fault if your partner harms you, even if you are drinking or using – regardless of what your partner or society tells you. Your use does not justify violence against you on any level. You deserve to be treated with dignity and respect" (Warshaw & Tinnon, 2018).

This may be the first time that she has ever told anyone about the violence in her relationship, and she may have some immediate (or later) regret and fears in doing so. Acknowledge that you understand how difficult it must be to be living with the stress of the relationship, and that you appreciate how brave she was to tell you about it. This will also go a long way in helping to establish your trust and rapport with her. Also, emphasize that by informing you about her situation, you can help better support her in treatment and recovery.

EDUCATION AND EMPOWERMENT

If a client discloses IPV, it is helpful to provide education about healthy vs. non-healthy relationships, and the effects and consequences of IPV. Futures Without Violence (www.futureswithoutviolence.org), as well as many of the organizations listed under "Additional Resources" in this document have numerous materials that can be used to provide this education. Many of these are free of charge and can be used as a regular part of the client assessment or intake packet. SUD providers should also discuss the possible coercion and treatment/recovery sabotage tactics that an abusive partner may use to maintain power and control. The Power and Control Wheel for Women's Substance Abuse (available at: http://www.ncdsv.org/images/WomensSubAbusewheelNOSHADING.pdf) may be a helpful tool to illustrate this. Additionally, the NCDVTMH toolkit on coercion has some excellent information about SUD coercion tactics: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2018/03/NCDVTMH_MHSUCoercionToolkit2018.pdf

CUES: An Evidence-Based, Trauma-Informed Intervention

C: CONFIDENTIALITY

Always see the patient alone for at least part of the visit and disclose your limits of confidentiality before discussing IPV.

UE: UNIVERSAL EDUCATION AND EMPOWERMENT

Talk with all patients about healthy and unhealthy relationships and the health effects of violence. Provide safety information.

S: SUPPORT

Disclosure is not the goal, but may occur when given the opportunity. Discuss a patient-centered treatment plan which encourages harm reduction. Make a warm referral to your IPV partner and document the disclosure in order to follow up at the next visit.

(Futures Without Violence, 2018)

An important part of education and empowerment is to also assess the survivor's safety level. Her immediate safety can be inquired about by asking, "Will you be safe when you leave here today (or when you go home)?" SUD providers can also assist with brief safety planning. Safety planning can help minimize the risk of harm when a violent episode occurs. Futures Without Violence provides a personal safety plan tool that may be helpful: https://www.futureswithoutviolence.org/userfiles/file/Maternal_Health/Safety%20plan%20English-Consensus%20Guidelines.pdf

In rural communities, safety planning and finding a safe place to go when needed can sometimes be difficult. She may be socially as well as geographically isolated from family and friends. The provider should talk with her and help her identify someone she might turn to in her local community, if needed.

Safety planning should also include helping her strategize how to be safe within her SUD treatment plan. This may involve talking with her about how it might be safest to contact her, including by what means as well as when and where; strategizing how to keep treatment related appointments; determining if stalking or harassment when attending appointments may be an issue of concern; if she has children, how will her treatment plan impact them (this may be particularly important if inpatient treatment is recommended); etc. (Warshaw & Tinnon, 2018).

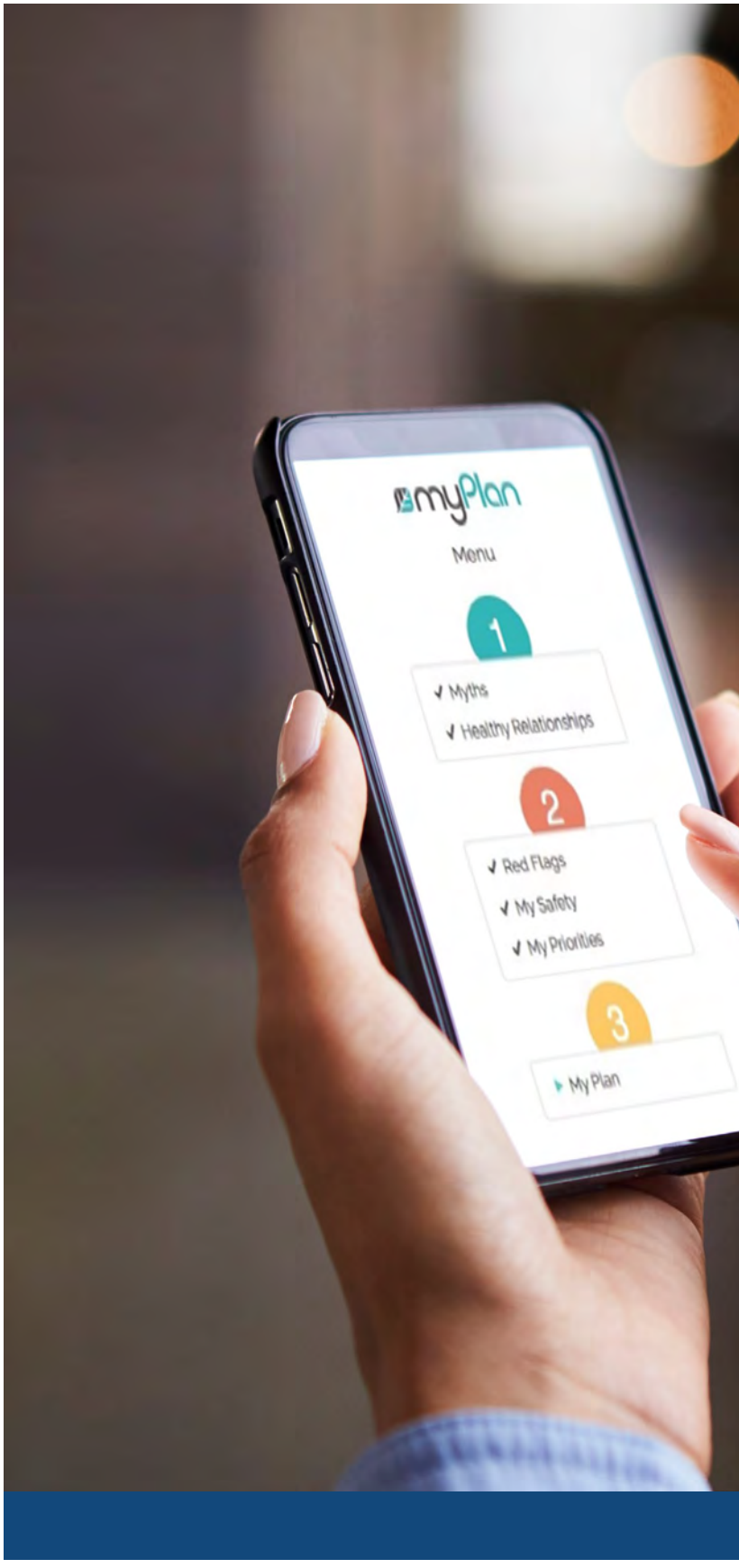
SUPPORT

Helping an IPV survivor receive information about possible sources of support is key for intervention.

Supportive professionals can help the survivor become less isolated, develop more detailed safety plans, understand her options, and receive support for her decisions about the relationship. You should familiarize yourself with any IPV programs and/or advocacy services in the local area. Any client who has disclosed IPV should be referred to IPV support and advocacy services. It may be helpful to ask if she has ever accessed IPV services in the past and if she would consider accessing services now. SUD providers should be familiar with local IPV services, and preferably have an established relationship with those services. In rural areas, it is possible that the nearest IPV services may be located many miles away. If you have a wide client catchment area, it may mean that you familiarize yourself with more than one IPV agency that serves survivors within that area. In order to provide a warm referral, you may want to offer to allow the client to use your office phone to call the local IPV resource. You can complement this with a brochure or card from the local IPV agency if it is safe for the client to take it with her.

In addition to local resources, it is also helpful to provide a survivor with the National Domestic Violence Hotline at 800-799-7233. An easy way to remember this number is 800-799-SAFE. The national hotline number is available to survivors, regardless of where they are located, and can get them in touch with local services in their area. This is a helpful resource for women to know about for times when she may be away from her home community, or in the case of rural survivors, if they are unable or do not want to access local services.

IPV survivors consistently report that one of the most helpful things they did to reduce violence is to access advocacy and support services. However, for a variety of reasons, the majority of IPV survivors do not access these services (Miller & Glass, 2018). Technology-based advocacy and interventions might be a promising way to provide IPV survivors with information and safety planning. The “myPlan” app (available at: https://www.myplanapp.org/) is a downloadable app (for computers, tablets, and smartphones) to identify and make safety decisions about an abusive relationship, or to help friends and family members support an IPV survivor. The “myPlan” app was developed through research by Johns Hopkins University and tested with thousands of survivors, domestic violence advocates, and healthcare providers. Survivors who used the “myPlan” app have been shown to have improved safety decision-making, increased use of safety strategies helpful for safety and well-being and were more likely to leave the relationship (Miller & Glass, 2018). SUD service providers may want to download the app onto a computer or tablet in their office, and assist clients with using it, or allow them to use it privately. This may be a particularly useful tool for use in rural areas, where IPV advocates may not be accessible or immediately available. Further, rural survivors, who have concerns related to confidentiality & privacy when accessing local services, may find the app more appealing, since the electronic app allows anonymity.



WHEN IPV IS SUSPECTED BUT NOT DISCLOSED

When IPV is suspected but not disclosed, the woman's choice must be honored. As mentioned, only she can know when it is safe for her, physically and emotionally, to disclose the abuse. However, regardless if disclosure occurs or not, intervention can still occur by offering educational information and available resources and services, including local and national hotline numbers. It is helpful to present the information in a way that respects her decision not to disclose yet empowers her with vital resources. For example, you might say, "I am really glad to hear that violence isn't part of your relationship. Please let me know if you would ever like to revisit this. Because we know that it happens in so many relationships, especially when substance use is involved, and because no one ever deserves to be abused, I'd like to offer you some information and resources so that you can help a friend, a sister, or any other women whom you care about, if need be." Then, allow the woman to determine whether or not she wants to take any information with her (Dudgeon & Evanson, 2014).

Another approach is to say, "Thank you for answering questions about intimate partner violence, as I know that might be difficult to talk about. Please know that I am always open to listening to any concerns you have with your relationship, because we know that those concerns can affect your treatment and recovery." You can revisit this issue again during subsequent meetings and as your relationship develops.

FINAL RECOMMENDATIONS FOR PRACTICE

- SUD treatment and recovery support providers should implement protocols that make universal questions to assess for IPV a part of assessment with all clients.
    - Regardless of the response to IPV screening, provide universal information and referral to local IPV services.
- Be very clear in your discussions with clients about how you will maintain confidentiality; but also discuss the limits of that confidentiality.
- Work with your local/state IPV and child welfare programs to establish cross-training for your agency/staff. Insure that all your SUD treatment/recovery staff receive training on IPV and child welfare. In turn, your agency can agree to provide SUD training for your local IPV and child welfare agencies/staff.
- Have IPV educational materials and referral information available for clients.
- An integrated approach will most effectively address IPV and behavioral health issues. However, integrated care may not be realistically achievable in rural areas, where health and human services are limited and may have large geographical distances separating them.
- Rural agencies and professionals working with women survivors of IPV who have behavioral health concerns (e.g., mental health providers, SUD providers, IPV agencies, primary care providers, law enforcement, first responders) could consider establishing memoranda of agreement to guide interagency collaboration regarding information sharing, referrals, and timely service referral and access. (Van Deinse et al., 2018)
- Trauma-informed treatment is helpful in working with IPV survivors. However, trauma-informed treatment may not be enough, as IPV survivors face issues that a general trauma model does not address:
    - Criminal justice issues related to IPV, unique from issues related to substances
    - Co-parenting with abusive partners and custody issues
    - Stalking and threats by current or former partners
    - Legal remedies such as protection orders
    - Coercive efforts by abusive partners to undermine survivors' SUD treatment and recovery (Macy & Goodbourn, 2012).
- IPV-informed and gender-specific treatment (SAMHSA, 2011) will have the best results.

JESSICA

AGE 27

GROCERY STORE CHECKER

MARRIED, 2 CHILDREN

CASE EXAMPLE

Now that you have an understanding of how IPV and SUDs intersect, the following case example of Jessica, a woman residing in a rural area, will help to illustrate the translation of this information to practice. As you read, consider for yourself how you might interact with and best support Jessica, given the unique circumstances in your practice and agency.

BACKGROUND

Jessica is a 27-year-old White female who is referred for substance use evaluation and possible referral to treatment services after being arrested for driving under the influence (DUI). Jessica was involved in a single motor vehicle crash, in which she crashed her car into an electrical pole along a county highway at 1:00 AM. Jessica's blood alcohol level was 0.21, well above the legal limit, and her serum toxicology screen taken in the Emergency Room also tested positive for marijuana. Jessica suffered only minor cuts and bruises in the accident.

COUNSELOR FIRST IMPRESSIONS

Theresa is a licensed SUD counselor who conducts Jessica's court-ordered assessment. The assessment is to determine if Jessica has a SUD or other mental health concerns and to make recommendations regarding level of care for SUD treatment and referrals for other health care issues including mental health. She notes that Jessica is quiet, reserved and has poor eye contact. Jessica seems embarrassed and remorseful about her recent DUI and arrest. Theresa observes that

Jessica has some bruises on her forehead that are beginning to fade, as well as an additional darker bruise on her left cheek and dark bruises on the backs of her forearms. When Theresa asks about her bruises, Jessica says, “Yeah, I got them in the car accident,” and pulls her sleeves down over her arms to cover the bruises located there.

Bruises of different degrees of healing may indicate injuries which occurred at varying points in time. It is not uncommon, during a violent episode, for women to put up their forearms to protect their face/head/chest. Injuries to the backs of forearms of this type are called defensive posture injuries.

ASSESSMENT

As a licensed SUD counselor, Theresa is skilled at SUD assessment. For other professionals, who are not trained in SUD assessment, an excellent evidence-based approach to identifying patients who use alcohol and other drugs at risky levels is Screening, Brief Intervention and Referral to Treatment (SBIRT) https://www.samhsa.gov/sbirt In this particular case the referral to treatment part of SBIRT will be the most helpful to Jessica.

Before beginning, Theresa explains to Jessica that what she shares with her will remain confidential, unless she signs a consent for the release of information to each specific person or entity according to the Federal Confidentiality Rules and Regulations 42 CFR Part 2. She also tells her about the requirements as a mandated reporter for child maltreatment and vulnerable adults and explains that these are legal mandates to report which are outside of the confines of these confidentiality rules and regulations.

Theresa learns that Jessica grew up in a very small town 35 miles from the treatment center where the evaluation is occurring. She has been married for seven years and has two children, ages six (male) and two (female). They rent an old farmhouse a few miles outside of the town where Jessica grew up. Jessica works as a checker at the local grocery story in her hometown. Her husband was working as part of a home construction crew but lost his job a few months ago and has been unable to find work since.

Findings from the evaluation include:

- Occasional alcohol and marijuana use in high school.
- Began drinking alcohol more often after she married her husband. Reports that she felt intoxicated after drinking five to six beers but now it takes her eight to nine beers to feel the same effect. She drinks heavily both Friday and Saturday nights with her husband plus four or five beers on Sunday.
- Jessica uses marijuana with alcohol and marijuana nightly to help her get to sleep.

As part of the assessment the counselor screens for risk of harm to self or others. Jessica indicates that while she is not suicidal now, she has had thoughts of suicide in the past. She states that she has never been prescribed medications

for depression or anxiety. Theresa suggests that Jessica visit her primary care provider for assessment of depression or other mental health concerns. Jessica indicates that she would not be comfortable discussing mental health concerns with the doctor she normally sees, because her cousin works in the doctor's office and she's worried she would find out and "spread it all over town". Theresa understands that providers in rural communities must also adhere to HIPAA requirements for confidentiality but also knows there can be general community chatter within a health care facility. She asks if Jessica would be interested in seeing a provider at the Community Health Center, which is a block away from the SUD treatment center and suggests that Jessica can call from her office before she leaves today.

TREATMENT PLAN

Theresa recommends that Jessica attend an intensive outpatient program as she meets the criteria for admission to treatment at this level according to the American Society of Addiction Medicine (ASAM) Criteria and Continuum of Care (2.1 Intensive Outpatient treatment). Theresa explains that this will involve 9 to 19 hours of group/services provided by a SUD professional per week. She also explains that as long as she is involved in treatment services, Jessica should be able to get a work permit to drive to/from work and her treatment.

ASAM criteria can be found at: https://www.asam.org/asam-criteria/about and DSM-V diagnosis/diagnostic criteria at: https://www.psychiatry.org/psychiatrists/practice/dsm

Theresa is trained in Motivational Interviewing and assesses Jessica's motivation for change in relation to her substance use. Jessica is uncertain and reluctant about her ability to make a change in her substance use. Her primary concern is about the number of hours she will have to spend in treatment services each week. She becomes very upset and states, "That's too much; I can't leave my kids alone with him that much." Theresa asks why she is worried about leaving her kids alone with her husband. Jessica quickly says, "No, that's umm…..I just can't be away from my kids that much. They need me."

For more information about the use of Motivational Interviewing with SUD treatment, please see SAHMSA's Quick Guide for Clinicians: https://store.samhsa.gov/product/Enhancing-Motivation-for-Change-in-Substance-Abuse-Treatment/SMA12-4097

SCREENING FOR SUD COERCION AND IPV

Theresa asks Jessica to describe her relationship with her husband. Jessica looks at her rather startled, and says, "It's fine. He's a good dad," and then looks down. Theresa asks, "How does he feel about your drinking and marijuana use?" To which Jessica replies, "Sometimes it makes him mad. But he uses too." Theresa then says, "Many people report their partner makes them use alcohol or other drugs, or makes it hard for them to stop or prevents them from stopping, or uses their alcohol or other drug use as a way to control them, or does other hurtful things related to their alcohol or other drug use. Does this sound like anything you might be experiencing?" (Warshaw & Tinnon, 2018). Jessica, looking down, responds, "Yeah, maybe some of those things." With further discussion, Jessica reports that her husband sometimes makes her drink more than what she would like, threatens to hurt her if she does not drink or use pot along

with him, and encourages her to drink so she's "more fun" in their sexual activities. Now that she has a DUI her husband has told her that if she ever leaves him, he'll get custody of the kids, because the judge will see her as "a drunk".

Theresa explains to Jessica that because drug and alcohol use is often tied to problems in a relationship or feeling unsafe in a relationship, she asks all her clients some routine questions that may help her understand Jessica's substance use history and will provide information for Theresa to help Jessica in her treatment plan. Theresa then asks the four IPV screening questions from the HITS tool (Shakil et al. 2014):

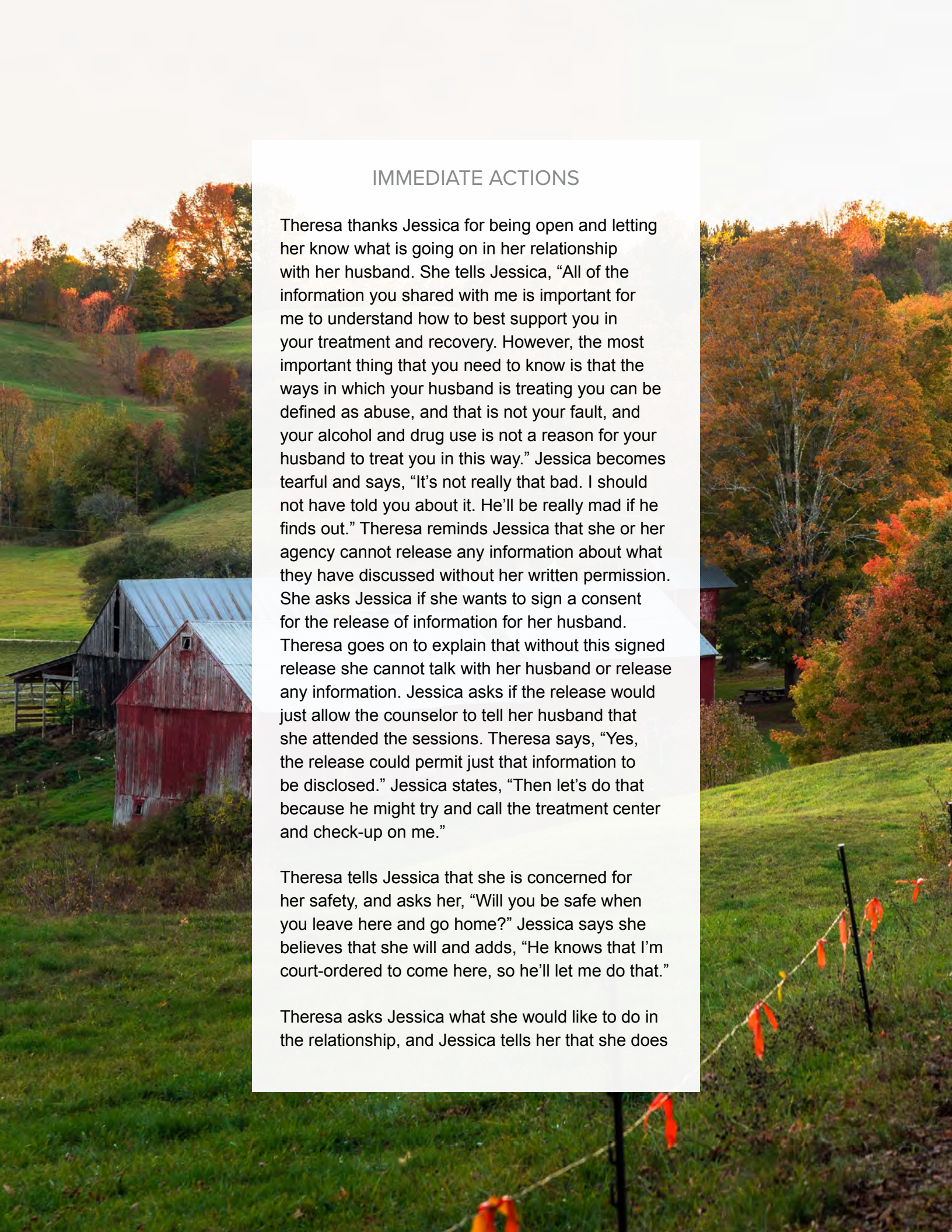
Does your partner

- Physically hurt you? (Jessica responds "sometimes")
- Insult you or talk down to you fairly often? (Jessica responds "yes")
- Threaten you with harm? (Jessica responds "sometimes")
- Scream or curse at you fairly often? (Jessica responds "yes")

In further discussion, Jessica confides that her husband sometimes made fun of her and called her names when they first started dating, "but he was just joking around." Shortly after they got married, he hit her for the first time after she refused to clean up a beer that he had spilled in the carpet. Since that time, "we argue a lot, more when we are drinking, but he doesn't hit me that often. He did get pretty mad when I crashed the car and got arrested for DUI, though."

Theresa asks Jessica if any of her friends or family know what she is experiencing in her relationship, and she tells Theresa that she was an only child. Her father died when she was young and her mother now lives in another state. She confides that she has few friends because her husband likes her to spend time with him and would get angry if she went out with friends. They used to rent a house in town, and on occasion, she was able to see some of her friends she had since high school. About two years ago her husband decided to rent a farmhouse a few miles outside of town. Her nearest neighbor is about two miles away and the only times she sees her friends now is at the grocery store where she works.

Theresa reminds Jessica that while the laws in her state do not require her to report IPV or child exposure to IPV, she is required to report any direct child maltreatment. Jessica states, "No, he never hurts the kids. He's a really good dad." She denies that he has ever physically hurt either of the children. She states the children are devoted to their father and he is a good dad but worries about the aggressive behaviors he is teaching their five-year-old son. She worries, in particular, about the impact of their son witnessing his father's anger in the home when he yells and screams. Her son is beginning to engage in the same behavior when he becomes angry. She has noted that he is aggressive with other children on play dates. Another parent has even talked with her about her concerns.



IMMEDIATE ACTIONS

Theresa thanks Jessica for being open and letting her know what is going on in her relationship with her husband. She tells Jessica, “All of the information you shared with me is important for me to understand how to best support you in your treatment and recovery. However, the most important thing that you need to know is that the ways in which your husband is treating you can be defined as abuse, and that is not your fault, and your alcohol and drug use is not a reason for your husband to treat you in this way.” Jessica becomes tearful and says, “It’s not really that bad. I should not have told you about it. He’ll be really mad if he finds out.” Theresa reminds Jessica that she or her agency cannot release any information about what they have discussed without her written permission. She asks Jessica if she wants to sign a consent for the release of information for her husband. Theresa goes on to explain that without this signed release she cannot talk with her husband or release any information. Jessica asks if the release would just allow the counselor to tell her husband that she attended the sessions. Theresa says, “Yes, the release could permit just that information to be disclosed.” Jessica states, “Then let’s do that because he might try and call the treatment center and check-up on me.”

Theresa tells Jessica that she is concerned for her safety, and asks her, “Will you be safe when you leave here and go home?” Jessica says she believes that she will and adds, “He knows that I’m court-ordered to come here, so he’ll let me do that.”

Theresa asks Jessica what she would like to do in the relationship, and Jessica tells her that she does

not want to leave her husband. She loves him and she just wants the abuse to stop. She is also very fearful that if she were to leave, she would lose custody of her children now that she has a DUI charge.

Next, Theresa asks if Jessica has ever utilized the IPV resources that are available in her community, or if she is aware of what is available. Jessica says that she did call them one time when she was contemplating leaving her husband, "but they are located way over in Richland" (a town 20 miles away). "They told me they could put me up at a safe house in Richland, but I know he would drive all over the county and find my car and then find us, and then he'd be really mad. So I never called them back." Jessica has also been afraid to call 911 because she and her husband were high school friends with the sheriff's son, and "I would just be too embarrassed and I don't even know if he would do anything."

Theresa tells Jessica that she will support whatever decision she makes with her relationship, but she wants to help her be as safe as she can. She asks if she would be willing to contact the local IPV advocacy services to talk with them about safety planning, but Jessica says, "No. I don't need to talk to them. It's not that bad, really." Theresa tells her about the "myPlan app" and shows it to her on her computer. Theresa asks Jessica to go through the questions on the app to help her determine the level of danger in her relationship with her husband. She tells her she will give her some privacy and will check back in with her when she is done. In using the "myPlan" app, Jessica learns that she may be in "severe" danger in her relationship. Theresa asks Jessica again if she would consider talking with one of the local IPV advocates. She tells Jessica that she knows the local IPV advocates and can call them and see if one could meet with Jessica over a video (telehealth) session and talk about her individual situation. Jessica agrees this time, and after getting the session set up on her office computer, Theresa gives Jessica some privacy in her office to talk with the IPV advocate.

When Theresa returns to her office, Jessica tells her that the IPV advocate she spoke with was helpful and gave her some ideas about what she could do to try to be safer in her relationship. The IPV advocate also suggested that she and Jessica teleconference over video and discuss some further options, and Theresa offers to help Jessica set this up either before or after she comes to her group SUD meetings.

Theresa shows Jessica the Power and Control Wheel for Women with SUDs, and Jessica says, "Yeah, he does a lot of those things." They discuss some of the ways that her husband uses coercion in relation to her alcohol and drug use and discuss possible strategies to cope with this.

NEXT SESSION

Jessica indicates to Theresa that she has not drank or used pot since their last meeting, but that her husband is trying to sabotage her efforts at completing her treatment program. He is drinking in front of her and is using marijuana frequently. He has been leaving both on the kitchen counter for her to see and becomes angry when she refuses to drink or smoke with him. She comes home to her two-year old in a diaper that needs to be changed and the six-year old enjoying non-stop screen time.

Jessica tells Theresa that she was able to see an Advanced Practice Nurse Practitioner (APRN) at the Community Health Center, and discussed her depression and anxiety. While she was asked questions about IPV, she did not feel comfortable disclosing at that time, and so she said no to all questions. The APRN (who was trained in addiction science and motivational interviewing, and understands the stigma associated with SUD) asked her about her drug and alcohol use. Jessica reports she told her that she is starting treatment for alcohol and marijuana use. After further discussion about her depression and anxiety, the ARPN prescribed an antianxiety/antidepressant medication for Jessica and asked her to return in four weeks for further assessment.

PROGRESS

For the next two weeks, Jessica continues to adhere to treatment recommendations. Her random drug/alcohol screens have tested negative and Theresa reminds her that as long as her screens remain negative, she will be able to keep her permit to drive to work, treatment, and her kids' activities. Jessica has met with the local IPV advocate via video conference twice, and Theresa allows her to use her computer in her office for these sessions.

Jessica reports that her husband has increased his frequency and amount of alcohol and marijuana use and continues to sabotage her treatment/ recovery in multiple ways. Jessica reports it is becoming more difficult to maintain her sobriety, as he is increasing his name calling and belittling of her. “He says I think I’m better than him because I’ve quit drinking, and that makes him angry.” He has not hit her again but makes frequent threats. She reports that he is becoming suspicious of her activities while at treatment meetings and accuses her of “talking with other guys.” Jessica reports that her husband has been trying to find work, but it is difficult because he has a reputation in their small community of drinking on the job and no one wants to hire him.

One day, Jessica’s husband calls the treatment agency and demands to know what Jessica is doing and talking about during the group. Theresa speaks with him and says to him “It appears that you are interested in Jessica’s treatment. Jessica has attended all her scheduled sessions and she would like to invite you to the family education session, which we think is helpful for family members.” Theresa provides him with the date and time of the family session. He does not attend.

While family treatment is encouraged when possible, caution needs to be used with family treatment in cases of IPV.

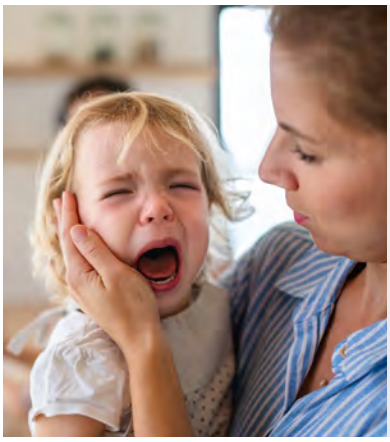
HOW DOES JESSICA'S STORY END?

There are any number of possible scenarios for how Jessica's story could end. Undoubtedly, all providers would want Jessica to fully engage with her treatment and recovery plan, follow up for her mental health needs, and receive the necessary IPV support and advocacy for her and her children to be safe and free from IPV. In the ideal ending to this case, Jessica would stay connected with her new provider at the Community Health Center for appropriate treatment for her depression and anxiety. She would attend all her treatment program appointments and group meetings and engage with her treatment plan. She would also access support services through the IPV program that serves her community, to identify options available to her, and assist with implementing the options that best serve Jessica and her children. However, in reality, there are many possible ways that Jessica's story could end. The following examples illustrate just some of the possibilities.

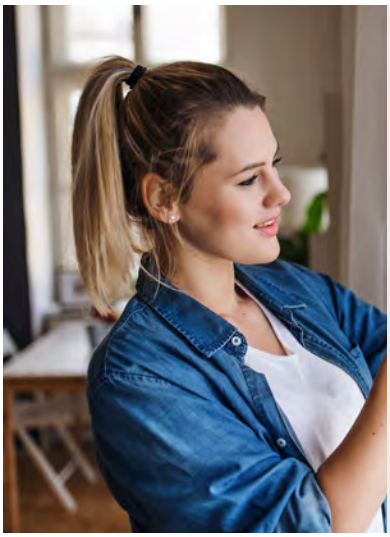
A. During a particularly explosive episode, when Jessica's husband threatens to shoot her with his hunting rifle, Jessica is able to call 911 and hide in the barn with her kids until the local deputy sheriff arrives 35 minutes later. Jessica's husband is arrested for IPV and is court ordered into batterers' treatment as well as SUD treatment services. Given the limited resources in the rural area, Jessica and her husband end up in the same treatment program. The agency is very conscious to make sure that they are put into separate groups, have different counselors, and individualize a treatment plan that is best for each of them. Jessica is now involved with the child protection system as the law enforcement officers who visited her home believe the children are at-risk. The child protection unit recommends that her son participate in therapy and that she leave the home for the safety of herself and her children. Jessica works with IPV advocates to obtain an order of protection and begins making plans to divorce her husband.

B. Jessica remains with her husband and does not continue with any IPV support services or follow-up with the APRN. Her husband insists on driving her to and from her treatment appointments and waits outside, monitoring her time spent there. Jessica eventually stops going to her SUD treatment services and returns to alcohol and marijuana use with her husband. Her son's teacher makes a report to child protective services because of continued aggressive behaviors and bruises that were noted on several occasions. After investigation by child protection, both children are placed in foster care.

C. Jessica does not follow up with the APRN for further evaluation and treatment of her depression. She continues with her SUD treatment, but one night her husband threatens to take the children and leave her if she does not get high with him. Jessica is fearful he will follow through with his threat and complies with his demands and drinks with him and smokes marijuana. Later, Jessica feels defeated and embarrassed to go back to treatment, knowing her urine screen will show she has returned to use. She feels depressed, and with little ability to cope with the trauma and abuse anymore, Jessica dies by suicide.



D. Jessica works with the local IPV services to fully develop a safety plan, with an eventual plan to leave the relationship. When she attempts to leave with her children, her husband becomes enraged and kills her, their two children, and himself.



E. Jessica is able to access support services for her IPV victimization. She returns to the APRN for follow-up of her depression and anxiety and reports fewer symptoms with medication. She remains in her relationship with her husband but begins to believe in her own worth again. Additionally, with the support and understanding of her situation by her SUD counselor, Jessica successfully completes her treatment program and is able to recognize her husband's coercion tactics and makes her best effort to work on her SUD recovery. However, her husband continues to use substances and his violence toward Jessica continues. Her son participates in play therapy with a trained counselor to address his aggressive behaviors at the same center where she receives treatment.

CONCLUSION

Jessica's story is not uncommon and provides a snapshot into the life of a rural woman with a SUD, in the context of trying to cope while living in a violent relationship. Theresa, Jessica's SUD counselor, creates a trusting space where Jessica can disclose the abuse that is occurring, provides validation that neither Jessica or her substance use are at fault for the abuse. By providing some brief intervention, through education and referral to services, Theresa creates opportunities for Jessica to receive the support she needs, not only for her substance use needs, but for her mental health and IPV needs as well. All of this increases the chances of Jessica breaking her isolation and receiving the needed support. While Jessica's eventual outcomes cannot be known, Theresa's actions enhance the chances for Jessica's successful treatment, recovery, and overall health.

Similar to other health care practitioners, SUD professionals can make a significant difference with clients involved in IPV. Increasing clinicians' knowledge, skills, and attitude about IPV can be achieved through in-service trainings using this product and many of the resources listed below. In addition, the Mountain Plains ATTC is available to provide additional training and technical assistance on IPV and SUDs and can be reached at www.mpattc.org.

ADDITIONAL RESOURCES

FUTURES WITHOUT VIOLENCE

https://www.futureswithoutviolence.org

Provides groundbreaking programs, policies, and campaigns that empower individuals and organizations working to end violence against women and children around the world. A multitude of resources and tools related to all types of violence are available. Client education materials are also available, many at no cost.

MOUNTAIN PLAINS ADDICTION TECHNOLOGY TRANSFER CENTER (MPATTC)

https://attcnetwork.org/centers/mountain-plains-attc/home

Provides training and technical assistance regarding substance use disorders to providers in HHS Region 8. Website has a wealth of trainings and products available.

MOUNTAIN PLAINS MENTAL HEALTH TECHNOLOGY TRANSFER CENTER (MPMHTTC)

https://mhttcnetwork.org/centers/mountain-plains-mhttc/home

Provides training, resources, and technical assistance to individuals serving persons with mental health disorders in HHS Region 8. Particular attention is given to agricultural communities.

NATIONAL CENTER FOR VIOLENCE PREVENTION AND CONTROL, CENTERS FOR DISEASE PREVENTION AND CONTROL (CDC)

https://www.cdc.gov/injury/

Provides data and evidence-based prevention and intervention strategies to address all types of violence, including IPV.

NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH

http://www.nationalcenterdvtraumamh.org

Provides training, support, and consultation to advocates, mental health and substance abuse providers, legal professionals, and policymakers as they work to improve agency and systems-level responses to survivors and their children. Very good resources on substance use coercion in IPV.

NATIONAL COALITION AGAINST DOMESTIC VIOLENCE (NCADV)

www.ncadv.org

NCADV serves as a national information and referral center; supports coalitions at the local, state, regional, and national levels; and advocates policy development and innovative legislation.

NATIONAL DOMESTIC VIOLENCE HOTLINE

www.thehotline.org

(800) 799-SAFE

Provides support, referral and crisis counseling to survivors as well as information for others. The website also offers live help through a private online chat feature.

NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

www.futureswithoutviolence.org/content/features/detail/790

The center offers a wealth of culturally relevant educational materials that are appropriate for a variety of health and human services settings. They also have client education materials, many at no cost.

NATIONAL ONLINE RESOURCE CENTER ON VIOLENCE AGAINST WOMEN

www.vawnet.org

This online resource library offers thousands of materials on violence against women and related issues.

RURAL HEALTH INFORMATION HUB: VIOLENCE AND ABUSE IN RURAL AMERICA

https://www.ruralhealthinfo.org/topics/violence-and-abuse

Provides information on FAQs, resources, organizations, models and innovations, and funding opportunities specific to rural areas.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION: TIP 25: SUBSTANCE ABUSE TREATMENT AND DOMESTIC VIOLENCE

https://store.samhsa.gov/product/TIP-25-Substance-Abuse-Treatment-and-Domestic-Violence/SMA12-3390

This guide presents treatment providers with an introduction to domestic violence and has useful information on the role of substance abuse in domestic violence.

REFERENCES

American Psychiatric Association (2020). What is a Substance Use Disorder? Retrieved from: https://www.psychiatry.org/patients-families/addiction/what-is-addiction

Bender, A.K. (2016). Healthcare experiences of women experiencing intimate partner violence and substance abuse. Journal of Social Work Practice in the Addictions, 16, 202-221.

Bennet, L. & Bland, P. (2008). Substance Abuse and Intimate Partner Violence. Harrisbug PA: VAWnet, Retrieved from: http://www.vawnet.org

Bent-Goodley, T.B. & Fowler, D.N. (2006). Spiritual and religious abuse: Expanding what is known about domestic violence. Journal of Women and Social Work, 21, 282-295.

Beydoun, H. A., Beydoun, M. A., Kaufman, J. S., Lo, B., & Zonderman, A. B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: A systematic review and meta-analysis. Social Science & Medicine, 75(6), 959-975. doi: http://dx.doi.org/10.1016/j.socscimed.2012.04.025

Beyer, K., Wallis, A.B. & Hamberger, L.K. (2015). Neighborhood environment and intimate partner violence: A systematic review. Trauma, Violence and Abuse, 16, 16-47.

Bushy A . (2006). Nursing in rural and frontier areas: Issues, challenges and opportunities. Harvard Health Policy Review, 7, 17-27.

Bushy A. (2020). Rural nursing: Healthcare delivery and practice issues. American Nurses Association Retrieved from: https://nursece.com/courses/146-rural-nursing-healthcare-delivery-and-practice-issuesPractice%20and%20Issues.

Campbell, J.C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M.A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S.A., Manganello, J., Xu, X., Schollenberger, J., Frye, V. & Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. American Journal of Public Health, 93, 1089-1097.

Centers for Disease Control and Prevention (CDC). (2010). National Intimate Partner and Sexual Violence Survey, 2010 Summary Report. National Center for Injury Prevention and Control, Division of Violence Prevention, Atlanta, GA.

Centers for Disease Control and Prevention (2018). Intimate Partner Violence: Consequences. Retrieved from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html

Centers for Disease Control and Prevention (2020). Risk and Protective Factors for Perpetration. Retrieved from: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html

Chang, J.C., Decker, M.R., Moracco, K.E., Martin, S.L., Petersen, R. & Frasier, P.Y. (2005). Asking about intimate partner violence: Advice from female survivors to health care providers. Patient Education and Counseling, 59, 141-147.

Chang, J.C., Dado, D., Ashton, S., Hawker, L., Cluss, P.A., Buranosky, R. & Scholle, S.H. (2006). Understanding behavior change for women experiencing intimate partner violence: Mapping the ups and downs using the stages of change. Patient Education and Counseling, 62, 330-339.

Cook-Craig, P.G., Lane, K.G. & Siebold, W.L. (2010). Building the capacity of states to ensure inclusion of rural communities in state and local primary violence prevention planning. Journal of Family Social Work, 13, 326–342.

Crosby, R.A., Wendel, M.L., Vanderpool, R.C. & Casey, B.R. (Eds.) (2012). Rural Populations and Health: Determinants, Disparities, and Solutions. San Francisco: Jossey-Bass. ISBN: 978-1-118-00430-2

Edwards, K.M. (2015). Intimate partner violence and the rural-urban-suburban divide: Myth or reality? A critical review of the literature. Trauma, Violence and Abuse, 16, 359-373.

Dudgeon, A. & Evanson, T.A. (2014). Intimate partner violence in rural U.S. areas: What every nurse should know. American Journal of Nursing, 114(5), 26-35.

Faller, Y.N., Wuerch, M.A., Hampton, M.R., Barton, S., Fraehlich, C., Juschka, D., Milford, K., Moffitt, P., Ursel, J. & Zederayko, A. (2018). A web of disheartenment with hope on the horizon: Intimate partner violence in rural and northern communities. Journal of Interpersonal Violence, 00(0), 1-26.

Favor, C. A., & Strand, E. B. (2003). To leave or to stay?: Battered women's concern for vulnerable pets. Journal of Interpersonal Violence, 18, 1367–1377. doi:10.1177/0886260503258028

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of Childhood Exposure to Violence, Crime, and Abuse: Results From the National Survey of Children's Exposure to Violence. JAMA Pediatrics, 169, 746–754. https://doi.org/10.1001/jamapediatrics.2015.0676

Futures Without Violence. (2018). Adopt the Evidence-Based CUES Intervention to Support Survivors and Prevent Violence. Retrieved from: http://ipvhealth.org/health-professionals/educate-providers/

Hansen, J.A. & Lory, G.L. (2020). Rural victimization and policing during the COVID-19 pandemic. American Journal of Criminal Justice, 45, 731-742.

Kimball, E. & Keene, C. (2016). Responding to the Long-term Needs of Adult Children Exposed to Domestic Violence: Exploring the Connection to Suicide Risk. National Resource Center on Domestic Violence. Retrieved from: https://vawnet.org/material/responding-long-term-needs-adult-children-exposed-domestic-violence-exploring-connection

Kimber, M., Adham, S., Gill, S., MacTavish, J. & MacMillan, H.L. (2018). The association between child exposure to intimate partner violence (IPV) and perpetration of IPV in adulthood: A systematic review. Child Abuse and Neglect, 76, 273-286.

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. Journal of Consulting and Clinical psychology, 71, 339–352. https://doi.org/10.1037/0022-006x.71.2.339

Lewy, C.S. & Dull, T.L. (2005). The response of Christian clergy to domestic violence: Help or hinderance? Aggression and Violent Behavior, 10, 647-659. DOI: 10.1016/j.avb.2005.02.004

Lippy, C., Jumarali, S.N., Nnawulezi, A. A., Williams, E. P., Burk, C., (2019). The impact of mandatory reporting laws on survivors of intimate partner violence: Intersectionality, help seeking, and the need for change, Journal of Family Violence, 35, 255–267.

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 and Abuse, 13, 234-251.

McLean, G. & Bocinski, S.G. (2017). The Economic Cost of Intimate Partner Violence, Sexual Assault and Stalking. Retrieved from: https://iwpr.org/publications/economic-cost-intimate-partner-violence-sexual-assault-stalking/

Miller, E. & Glass, N. (2018). Healing Centered Engagement: The Role of Health Providers and the myPlan Decision Aid App in Rethinking Harm Reduction and Trauma-Informed Care. Webinar. Available at: https://www.futureswithoutviolence.org/healing-centered-engagement-myplan-webinar/

Millett, L.S., Kohl, P.L., Johnson-Reid, M., Drake, B., & Petra, M. (2013). Child maltreatment victimization and subsequent perpetration of young adult intimate partner violence: An exploration of mediating factors. Child Maltreatment, 18, 71-84.

myPlan app: Available at www.myplanapp.org

National Advisory Committee on Rural Health and Human Services (2015) Intimate Partner Violence in Rural America. Policy Brief. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2015-partner-violence.pdf

National Child Traumatic Stress Network. (2021). Child Abuse Prevention. Retrieved from: https://www.nctsn.org/resources/public-awareness/child-abuse-prevention

National Coalition Against Domestic Violence (2018). Domestic Violence and the LGBT Community. Retrieved from: https://ncadv.org/blog/posts/domestic-violence-and-the-lgbtq-community

National Institute on Drug Abuse (2018). Understanding Drug Use and Addiction Drug Facts. Retrieved from: https://www.drugabuse.gov/publications/drugfacts/understanding-drug-use-addiction

Paranjape, A., Rask, K. & Liebschutz, J. (2006). Utility of STaT for the identification of recent intimate partner violence. Journal of the National Medical Association, 98, 1663-1669. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569753/pdf/jnma00197-0107.pdf

Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P. & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. Journal of Women's Health, 20, 1743 - 1749.

Phillips, H., Schaefer, S., White-Domain, R., & Warshaw, C. (2019). Saving lives: Meeting the needs of intimate partner violence survivors who use opioids. Chicago, IL: National Center on Domestic Violence, Trauma & Mental Health.

Riddell, T., Ford-Gilboe, M., & Leipert, B. (2009). Strategies used by rural women to stop, avoid, or escape from intimate partner violence. Health Care Women International 30, 134-59.

Rivera, E. A., Phillips, H., Warshaw, C., Lyon, E., Bland, P. J., & Kaewken, O. (2015). An Applied Research Paper on the Relationship between Intimate Partner Violence and Substance Use. Chicago, IL: National Center on Domestic Violence, Trauma & Mental Health.

Shakil, A., Bardwell, J., Sherin, K., Sinacore, J.M., Zitter, R. & Kindratt, T.B. (2014). Development of verbal HITS for intimate partner violence screening in family medicine. Family Medicine, 46, 180-185. Available at: https://www.stfm.org/FamilyMedicine/Vol46Issue3/Shakil180

Semler, J.L., Semler, B.J., & Wetterson, K. (2010). Midwest domestic violence shelters: Increasing multiculturalism training to improve communication between staff and Native American women. Journal of Rural Community Psychology, E13.1

Smith, P.H., Homish, G.G., Leonard, K.E., & Cornelius, J.R. (2012). Intimate partner violence and specific substance use disorders: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions. Psychology of Addiction Behavior, 26(2). Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3883081/

Smith, S. G., Zhang, X., Basile, K.C., Merrick, M.T., Wang, J., Kresnow, M., & Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief—Updated Release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Sohal, H., Eldridge, S. & Feder G. (2007). The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: A diagnostic accuracy study in general practice. BMC Family Practice, 8, 49. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/

Substance Abuse and Mental Health Services Administration (SAMHSA}.(2011). Addressing the needs of women and girls: Developing core competencies for mental health and substance abuse service professionals (HHS Pub. No. SMA 11-4657). Retrieved from http://store.samhsa.gov/shin/content//SMA11-4657/SMA11-4657.pdf

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Retrieved from: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Substance Abuse and Mental Health Services Administration. (2015). Substance Abuse Treatment and Domestic Violence: Quick Guide for Clinicians Based upon Tip 25. Retrieved from: https://store.samhsa.gov/product/Substance-Abuse-Treatment-and-Domestic-Violence/sma15-3583

Substance Abuse and Mental Health Services Administration. (2021). Intimate Partner Violence and Child Abuse Considerations During COVID-19. Retrieved from: https://www.samhsa.gov/sites/default/files/social-distancing-domestic-violence.pdf

U.S. Preventive Services Taskforce. (2018). Intimate Partner Violence, Elder Abuse, and Vulnerable Adults: Screening. Retrieved from: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening

Van Deinse, T.B., Wilson, A.B., Macy, R.M. & Cuddeback, G.S. (2018). Intimate partner violence and women with severe mental illnesses: Needs and challenges from the perspectives of behavioral health and domestic violence providers. Journal of Behavioral Health Services and Research, 46, 283-293.

Vittes, K.A. & Sorenson, S.B. (2008). Restraining orders among victims of intimate partner homicide. Injury Prevention, 14, 191-195.

Warshaw, C., Foley, K., Alpert, E.J., Amezcua, N., Feltes, N., Cerulli, C., Murphy, G., Bland, P., Carlucci, K., & Draper, J. (2018). Recommendations for Suicide Hotlines on Responding to Intimate Partner Violence. Chicago, IL: National Center on Domestic Violence, Trauma & Mental Health. Retrieved from: http://www.nationalcenterdvtraumamh.org/2019/04/recommendations-for-suicide-prevention-hotlines-on-responding-to-intimate-partner-violence/

Warshaw, C., Lyon, E., Bland, P.J., Phillips, H. & Hooper, M. (2014). Mental health and Substance Use Coercion Surveys: Report from the National Centaer on Domestic Violence, Trauma and Mental Health and the National Domestic Violence Hotline. Available at: www.nationacenterdvtraumamh.org

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 & Mental Health. Retrieved from: http://www.nationalcenterdvtraumamh.org/publications-products/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence-a-toolkit/

Warshaw, C. & White-Domain, R. (2014). How Gender Stereotypes and Stigma Associated with Mental Health and Substance Use Impact Survivors of Domestic Violence and Sexual Assault. Chicago, IL: National Center on Domestic Violence, Trauma & Mental Health. Retrieved from: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2015/04/Gender_Stereotypes_Myths_FINAL.pdf

Woods, S. (2005). Intimate partner violence and post-traumatic stress disorder symptoms in women: What we know and need to know. Journal of Interpersonal Violence, 20, 394.

World Health Organization. (2012). Understanding Violence Against Women: Health Consequences. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/77431/WHO_RHR_12.43_eng pdf;jsessionid=5FD8DAB9914E881FD1E83FA059B1B1D3?sequence=1

ABOUT THE AUTHORS

Tracy A. Evanson, PhD, RN, PHNA-BC

Tracy A. Evanson is a Professor at the University of North Dakota and member of the Mountain Plains ATTC team. Dr. Evanson has an extensive background in intimate partner violence (IPV), working with women and children survivors in shelters, corrections, and home settings. She has previously served as a Board Member and Vice President of the Nursing Network on Violence Against Women, International (NNVAWI), the primary international nursing organization dedicated to eliminating violence against women. Dr. Evanson has expertise in qualitative research, and her focus of research is IPV, specifically related to rural populations. In 2016, she received the Outstanding Researcher Award from NNVAWI. She also teaches several graduate courses related to rural health and rural populations. Dr. Evanson is a first generation college graduate and grew up in a rural North Dakota community of about 200 people.

Thomasine Heitkamp, LCSW

Thomasine is the PI and Co-Director of Mountain Plains Addiction Technology Transfer Center (ATTC) and Mountain Plains Mental Health Technology Transfer Center (MHTTC), and is a Chester Fritz Distinguished Professor at the University of North Dakota. She brings extensive expertise as an educator and former child welfare practitioner. Her academic efforts include expanding access to use of technology to enhance capacity among the behavioral health workforce in tribal and rural communities. She has taught both graduate and undergraduate social work courses on family violence and child welfare. Professor Heitkamp has a host of peer-reviewed publications and also serves as an author on practice-based tool kits. She is the lead author of the 2019 tool-kit entitled Promoting Positive Mental Health in Rural Schools, a contributing author of the 2020 tool-kit entitled Depression, Alcohol and Farm Stress: Addressing Co-occurring Disorder in Rural America and a co-author of the 2020 tool-kit entitled Strengthening Resilience: Promoting Positive Mental Health Among Indigenous Youth. The Council on Social Work Education recognized her for her innovative and practice-based approach to her academic career by awarding her the Distinguished National Pioneer in Distance Education in 2016.

ACKNOWLEDGEMENTS

Thank you to members of the Mountain Plains ATTC team who assisted with content expertise, editing, and graphic design:

Kim M. Miller MS, LMAC, LPCC

Associate Project Director, Mountain Plains ATTC

Nancy Roget, MS, MFT, LADC

Co-Director, Mountain Plains ATTC

Joyce Hartje, PhD

Evaluator, Mountain Plains ATTC

Shannon McCarty

Project Coordinator, Visual Communications and Marketing

CASAT, University of Nevada, Reno

DISCLAIMER

This publication was prepared for the Mountain Plains Addiction Technology Transfer Center (Mountain Plains ATTC) under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA). All material appearing in this publication, except that taken directly from copyrighted sources, is in the public domain and may be reproduced or copied without permission from SAMHSA or the authors. Citation of the source is appreciated. Do not reproduce or distribute this publication for a fee without specific, written authorization from the Mountain Plains ATTC. For more information on obtaining copies of this presentation please visit: ATTCnetwork.org/mountainplains.

At the time of this publication, Tom Coderre served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of Dr. Tracy Evanson and Thomasine Heitkamp and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

The work of the Mountain Plains ATTC is supported by grant TI080200_01 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains ATTC (HHS Region 8)

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Substance Abuse and Mental Health Services Administration

SAMHSA