SUMMARY AND REPORT:

SUBSTANCE USE COERCION AS A BARRIER TO SAFETY, RECOVERY, AND ECONOMIC STABILITY: IMPLICATIONS FOR POLICY, RESEARCH, AND PRACTICE

OCTOBER 24-25, 2019 | TECHNICAL EXPERT MEETING

NATIONAL Center on Domestic Violence, Trauma, and Mental Health

Carole Warshaw, MD
Heather Phillips, MA
Elaine Alpert, MD
Jasmin Brandow, MA
Crystal Brandow, PhD

Produced by the National Center on Domestic Violence, Trauma, and Mental Health

This publication is supported by Grant # 90EV0437-01-00 from the Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services. Points of view in this document are those of the authors and do not necessarily reflect the official positions or policies of the U.S. Department of Health and Human Services.

Preferred citation: Warshaw, C., Phillips, H., Alpert, E., Brandow, J., Brandow, C. (2020). Substance use coercion as a barrier to safety, recovery, and economic stability: Implications for policy, research, and practice: October 24-25, 2019 Technical Expert Meeting summary and report. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health.

TABLE OF CONTENTS

02 **EXECUTIVE SUMMARY**

06 **INTRODUCTION**

09 **MEETING SUMMARY**

09 **DAY 1**

28 **DAY 2**

48 **REFERENCES**

50 **SPEAKER BIOGRAPHIES**

56 **PARTICIPANT LIST**

60 **NCDVTMH STAFF AND CORE CONSULTANTS**

EXECUTIVE SUMMARY

OVERVIEW

Substance use coercion is a critical issue for survivors of intimate partner violence (IPV) that has widespread implications for state and federal policymakers and for the domestic violence and substance use disorder treatment and recovery fields. Survivors and advocates have long described the ways that abusive partners harm IPV survivors through coercive tactics focused on substance use, as part of a broader pattern of abuse, violence, and control. These tactics are known as substance use coercion (Warshaw et al., 2014). Common forms of substance use coercion include deliberately introducing a partner to substances, forcing or coercing them to use, interfering with their access to treatment, sabotaging their recovery efforts, and leveraging the stigma associated with substance use to discredit them with potential sources of safety and support.

Substance use coercion creates major barriers to safety and recovery for survivors of IPV, limiting their ability to engage in services and achieve health, wellbeing, and economic self-sufficiency. In order for services to be effective, safe, and accessible to survivors, practitioners and policy makers need to understand the ways that substance use coercion impacts survivors and their children. In light of these issues, a federal Technical Expert meeting was convened in October 2019 to improve understanding about the prevalence and impact of substance use coercion and to generate recommendations for policy, research, and practice.

This Technical Expert Meeting was part of a larger initiative under the leadership of The United States Department of Health and Human Services (HHS), Administration for Children and Families, Family and Youth Services Bureau's (FYSB) Family Violence Prevention and Services (FVPSA) Program; the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE); and the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH). In advance of the meeting, ASPE, FVPSA, and NCDVTMH conducted a literature review and a series of key informant interviews to delineate the prevalence, manifestations, and impacts of substance use coercion, and to identify innovative service models as well as barriers to accessing care. These activities informed the Technical Experts meeting, and summaries of both the literature review and key informant interviews are available.

Over 50 people attended this meeting, including federal partners, national stakeholders, researchers, domestic violence advocates, substance use treatment providers, and individuals with lived experience. Participants discussed current research on substance use coercion; listened to insights and recommendations from people directly impacted by substance use coercion; shared knowledge about innovative responses to the intersecting issues of substance use, substance use coercion, and IPV; highlighted critical research needs; and explored potential strategies to address substance use coercion by federal agencies and by the domestic violence, substance use, health, mental health,

legal, and child welfare fields. This report summarizes the proceedings and recommendations from the Technical Expert Meeting.

MEETING STRUCTURE

Day 1 included opening remarks from federal partners, a summary of current scholarship on substance use coercion, and three panel discussions. *Panel 1* featured the insights of individuals with lived experience. *Panel 2* showcased the work of integrated and collaborative IPV and substance use services. *Panel 3* addressed the importance of conducting research on substance use coercion; identified critical research gaps; and offered recommendations for expanding research on IPV, substance use, and substance use coercion.

Day 2 focused on generating recommendations in three key areas: 1) improving services; 2) reducing stigma, barriers, and harms; and 3) developing and implementing a research agenda on substance use coercion. Participants offered ideas about services that would be most helpful for people experiencing substance use coercion, ways to reach survivors who are not currently accessing services, and how to evaluate and bring to scale promising service models.

KEY FINDINGS

Supported by the literature review, key informant interviews, and two recent national surveys, major findings generated from the Technical Expert Meeting include the following:

- Coordinated and integrated IPV-substance use treatment services uniquely benefit survivors and are associated with decreased substance use, and in some cases, decreased experiences of violence.
- To date, integrated services have had limited uptake, highlighting the need to support the development and replication of integrated service models and community-level interventions.
- Domestic violence programs need additional resources to serve survivors experiencing substance use coercion. Only 20% of surveyed programs felt "very prepared" to support survivors who use substances; even fewer felt prepared to meet the needs of survivors who use substances and are parenting (Phillips, et al., 2020a).
- While there is strong interest in collaboration between state domestic violence and substance use administrations and systems, only 19% of state substance use disorder treatment systems currently have solid partnerships with state domestic violence agencies (NCDVTMH and the National Association of State Alcohol and Drug Abuse Directors, 2020)
- Substance use coercion creates barriers for survivors, impacting their ability to access services, engage in treatment, maintain recovery, retain custody of their children, and attain economic self-sufficiency. For example, more than 60% of survivors who sought treatment for substance use reported their abusive partner had tried to prevent or discourage them from getting help (Warshaw et al., 2014).

- Stigma associated with substance use and lack of recognition of substance use coercion creates service and system barriers for survivors.

> **Many survivors experience services as harmful rather than helpful due to substance use-related stigma, particularly in relation to parenting. As one expert said during the meeting, "People won't ask for help if they are being told how bad they are. We have to make it safe for people. There is nothing worse than putting the most vulnerable moment of your life out there and being told you are horrible."**

- IPV and substance use coercion increase the risk for opioid use disorder, opioid-related overdose, and pose unique risks for survivors (Gilbert, 2019).
- There is an urgent need for additional research on substance use coercion.

RECOMMENDATIONS

Meeting participants recommended concrete actions that can be taken by federal, state, and local officials; by substance use disorder and domestic violence systems; and by the research field. Participants strongly emphasized that strategies need to be developed, implemented, and evaluated in partnership with people who have lived experience of substance use coercion.

Priority recommendations include to:

- Increase access to integrated services by 1) supporting the development, implementation, and evaluation of a continuum of integrated IPV and substance use services and 2) by reducing barriers including transportation and childcare.
- Encourage programs to incorporate peer support, harm reduction, and two-generation approaches, informed by people with lived experience.
- Support funding requirements that include integrated responses to IPV and substance use coercion in all substance use disorder treatment settings.
- Support initiatives that promote cross-sector collaboration and training to address substance use, substance use coercion, and IPV.

> **In order for domestic violence and substance use disorder treatment services to be more effective, safe, and accessible for survivors, urgent action is needed to develop and scale coordinated, co-located, and integrated services.**

- Provide support to culturally specific and Indigenous domestic violence programs to respond to survivors who use substances and to evaluate innovative approaches.

- Prioritize both qualitative and quantitative research to better understand the prevalence, context, and impact of substance use coercion, including the effects of social, racial, and economic disparities on substance use and recovery.
- Fund implementation and evaluation research on interventions for substance use coercion, including community-level interventions.

A detailed list of recommendations is contained in the body of this report.

CONCLUSION

Substance use coercion is a complex issue that profoundly affects IPV survivors' ability to achieve safety and recovery. Addressing the multiple barriers to service access and engagement is a critical priority for state and federal policymakers, for local domestic violence and substance use disorder treatment providers, and for survivors and their families.

INTRODUCTION

Substance use coercion is a prevalent but under-recognized form of abuse that has widespread implications for the domestic and sexual violence, substance use, mental health, child welfare, legal, and housing fields, as well as for efforts to address the current opioid epidemic.

While research has consistently documented that abuse by an intimate partner increases a person's risk for developing a range of mental health conditions including depression, post-traumatic stress disorder (PTSD), suicidality, chronic pain, and substance use (Beydoun et al., 2017; Rivera et al., 2015; Trevillion et al., 2012), many survivors also experience substance use coercion: coercive tactics specifically targeted toward a partner's use of substances as part of a broader pattern of abuse and control (Warshaw & Tinnon, 2018). A survey conducted by the National Domestic Violence Hotline in partnership with NCDVTMH found disturbingly high rates of substance use coercion among hotline callers, providing the first large scale, quantitative data on this issue (Warshaw et al., 2014).

Substance use coercion typically involves the use of force, threats, and manipulation by an abusive partner. Common tactics include:

- **Forcing or coercing a partner to use substances, including to the point of developing physiological dependence or a diagnosable substance use disorder (SUD);**
- **Preventing a partner from accessing SUD treatment and recovery supports;**
- **Controlling a partner's ability to take medication as prescribed;**
- **Actively sabotaging a partner's recovery or their efforts toward cessation of use;**
- **Undermining a survivor's efforts at help-seeking by making them think that no one will believe them;**
- **Leveraging a partner's substance use and associated stigma as a way to keep them from leaving the relationship;**
- **Threatening to report a partner to authorities as a way to manipulate or control them; and**
- **Discrediting a partner with sources of protection and support (Phillips et al., 2020b; Warshaw et al., 2014).**

Substance use coercion can have devastating and wide-ranging effects on survivors and their children. Survivors who use substances face a constellation of risks to their safety and well-being posed both by their abusive partners and by the substances themselves. These forms of abuse not only compromise survivors' ability to engage in substance use treatment but also make it harder for survivors to access domestic violence services, maintain custody of their children, and access law enforcement or the courts. Stigma associated with substance use contributes to the effectiveness of these tactics and creates additional barriers for survivors and their children when they try to seek help. Substance use coercion also makes it harder for survivors and their children to leave abusive and violent relationships. These are critical issues, as both intimate partner violence (IPV)[1] and substance use increase the risk of harm – including fatality – from overdose as well as from violence (Gilbert, 2019).

Emerging knowledge about the intersection of IPV, substance use, and substance use coercion underscores the importance of addressing substance use coercion as part of opioid prevention and intervention strategies. For example, abuse by an intimate partner increases a person's risk for opioid use. Moreover, a significant proportion of people accessing opioid use disorder (OUD) treatment programs have experienced IPV (Engstrom et al., 2012). Yet there has been little attention paid to the role of IPV and substance use coercion in people's opioid use, opioid-related medical complications, and opioid-related deaths—issues that are critical to consider in developing strategies to address the opioid epidemic. IPV survivors who use opioids encounter a unique constellation of risks that directly threaten their physical safety and well-being. For example, it is not uncommon for an abusive individual to introduce a partner to opioids, control their supply, and then threaten them with withdrawal, loss of custody, incarceration, or physical violence if they try to reduce their use, access treatment, call the police, or resist demands to engage in illegal activities. Other unique risks include coercion into unsafe use, medication sabotage, and being stalked while attending regularly scheduled appointments.

Growing recognition of the potential impact of substance use coercion on the current opioid epidemic underscores the importance of incorporating IPV-specific interventions into OUD treatment and recovery services, as well as addressing IPV as part of broader opioid prevention efforts. Again, because substance use coercion leverages the stigma—and in some cases the illicit nature—of substance use, survivors face heightened risks related to criminal legal system involvement and incarceration, housing instability and homelessness, loss of child custody, and restricted options for economic self-sufficiency and employment. When survivors experience additional forms of marginalization and face systemic barriers, the risks posed by substance use coercion are further amplified.

Research suggests that IPV and substance use are interrelated. People who experience IPV are more likely to use substances compared to people who are not abused; people who use substances are more

1 In this report, the term 'intimate partner violence' is used when describing abuse by an intimate partner. The term 'domestic violence' is used, as per convention, when describing services that address intimate partner violence (i.e., domestic violence programs). Intimate partner violence (IPV) is best understood as intentional, ongoing, and systematic abuse intended to exert power and control over an intimate partner (Warshaw & Tinnon, 2018). The spectrum of IPV includes intimidation, threats, physical violence, verbal abuse, sexual violence, enforced isolation, economic abuse, stalking, psychological abuse, and coercion (Bancroft, 2003; Johnson & Leone, 2005; Stark, 2007).

likely to experience IPV compared to people who do not use (Rivera et al., 2015). In addition, research has consistently documented high rates of IPV among people seen in SUD treatment settings, as well as high rates of substance use among people seeking domestic violence services, underscoring the need for more integrated approaches to substance use and IPV (Macy & Goodbourn, 2012; Rivera et al., 2015). Advocates, survivors, and others in the domestic violence field have long described how abusive partners leverage substance use and substance use-related stigma to harm and entrap survivors (Edmund & Bland, 2011). However, there are major gaps in research, practice, and policy related to substance use coercion that need to be addressed.

In response to these concerns, and as part of a broader initiative to advance existing research, policy, and practice, the United States Department of Health and Human Services (HHS), Administration for Children and Families, Family and Youth Services Bureau's (FYSB) Family Violence Prevention and Services (FVPSA) Program, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), and NCDVTMH convened a Technical Expert Meeting in October 2019. The purpose of the meeting, *Substance Use Coercion as a Barrier to Safety, Recovery, and Economic Stability: Implications for Policy, Research, and Practice*, was to raise awareness among federal agencies, policymakers, and the domestic violence and substance use treatment fields about the prevalence and impact of substance use coercion and to encourage policy and practice innovations to address this critical issue.

In preparation for the Technical Expert Meeting, NCDVTMH, ASPE, and FVPSA conducted a literature review documenting the current state of research on substance use coercion and integrated services for substance use and IPV, plus a series of interviews with key informants from the domestic violence, substance use, and human trafficking fields.[2] The goals of the key informant interviews were to:

1. Gather information on the dimensions of substance use coercion;
2. Understand the impact of substance use coercion on survivors' health, safety, recovery, and economic stability;
3. Learn more about the impact of substance use coercion on opioid use, addiction, and overdose-related deaths;
4. Explore ways that substance use coercion impacts survivors' service engagement and outcomes; and
5. Identify broader policy and practice changes needed to better respond to substance use coercion.

Findings from the key informant interviews and the literature review can be found in two companion reports: *Theme Report – Understanding Substance Use Coercion in the Context of Intimate Partner Violence: Implications for Policy and Practice* (Phillips et al., 2020b) and *Literature Review: Intimate Partner Violence, Substance Use Coercion, and the Need for Integrated Service Models* (Phillips et al., 2020c).

2 These semi-structured discussions asked the same question of no more than nine people. ASPE and NCDVTMH developed separate semi-structured interview guides for individuals with lived experience, domestic violence experts, substance use experts, human trafficking experts, integrated programs, policy experts, and researchers.

MEETING SUMMARY

This section presents a summary of the October 24-25, 2019 Technical Expert Meeting, *Substance Use Coercion as a Barrier to Safety, Recovery, and Economic Stability for Survivors of Intimate Partner Violence: Implications for Policy, Research, and Practice*. It provided an opportunity to discuss:

- The current state of knowledge about substance use coercion;
- Insights and recommendations from people directly impacted by substance use coercion;
- Innovative responses to the intersecting issues of substance use, intimate partner violence (IPV), and substance use coercion; and
- Potential strategies for addressing substance use coercion by federal agencies and by the domestic violence, substance use, health, mental health, legal, and child welfare fields.

The Technical Expert Meeting was held at the US Department of Health and Human Services (HHS) in Washington, DC.

Day 1: October 24, 2019

WELCOME AND OPENING REMARKS

Kenya M. Fairley, MSEd, Supervisory Program Specialist, Division of Family Violence Prevention and Services, Family Violence Prevention and Services Act (FVPSA) Program, welcomed meeting participants, noting the diverse constituencies represented in the room, including federal policymakers, nonprofits, domestic violence organizations, researchers, and people with lived experience of substance use, substance use coercion, and IPV. Ms. Fairley outlined the agenda planned for the ensuing 1.5 days, including lectures, panel presentations, group discussions, and question and answer time. She drew attention to the reflection and journaling sheets and encouraged their use throughout the meeting to capture participants' thoughts and to deepen the exchange of ideas. Ms. Fairley shared that she looked forward to some amazing discussions and thanked all the partners involved in organizing the meeting.

Elizabeth Darling, Commissioner, HHS, Administration for Children, Youth, and Families (ACYF), led the opening remarks, highlighting her deep commitment to the agency's work. She spoke about the programs supported by ACYF (e.g., child abuse and neglect, foster care, adoption, adolescent pregnancy prevention, runaway and homeless youth, and family violence prevention and services) and about the importance of "getting it right" at each point along this continuum of care. She noted that, "If we don't get it right, we know all too well that when youth aging out of the foster care system leave without permanency and connections to help them along their path, they are likely to

come to the attention of the services being talked about today." Commissioner Darling also shared an inspiring personal story about her experience of adopting a 16-year-old who had been in foster care. She thanked the participants and federal agency partners—Department of Justice (DOJ), Housing and Urban Development (HUD), ASPE, and other agencies within HHS—adding that if we do not coordinate across systems, then we miss thousands of opportunities to reach out to people who need our help. Commissioner Darling added that this meeting is a way to explore the intersection of domestic violence and substance use coercion and to put a name to what people in the field and people with lived experience have been talking about for many years. Commissioner Darling added that the only way to generate effective change is at the local level, with community-based, multidisciplinary, trauma-informed systems of care involving the whole community. Commissioner Darling emphasized, "It is all local when you come down to it; it's one person, one family, and one relationship at a time."

Shawndell Dawson, Director, Division of Family Violence Prevention and Services, Family Violence Prevention and Services Act (FVPSA) Program, talked about the Program's commitment to cross-agency collaboration and thanked the Commissioner for her leadership. Director Dawson thanked participants for coming together to build a strategy to move this work forward and highlighted how for 35 years, HHS has stood in partnership with the FVPSA Program to address the needs of domestic violence survivors and their families. She talked about the importance of a public health response to domestic violence, emphasizing that the continuum of resources that families need includes substance use, mental health, domestic violence, and early childhood services along with trauma-informed supports. Director Dawson underscored that survivors are the true experts on what "we are investing in and what works" and "have been sounding an alarm about this need for a long time." She shared that she was grateful that the group would get to hear and learn from people with lived experience about how best to work together and make changes on the ground. She said, "What we learn today will impact all of us…this is really a story for all of us around [creating] the change we're trying to usher in…. You all represent [an] important [part of that] change and I want to thank you for that commitment." Finally, Director Dawson said that FVPSA stands in partnership with ASPE, the Office on Violence Against Women, Temporary Assistance for Needy Families (TANF), and the Early Childhood Office in their efforts to leverage the knowledge and expertise necessary to ensure that people "don't have to decide between recovering from addiction, caring for family, or being safe."

OVERVIEW AND FRAMEWORK: THINKING ABOUT SUBSTANCE USE COERCION IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE

Carole Warshaw, MD, Director, NCDVTMH, presented "Substance Use Coercion as a Barrier to Safety, Recovery, and Economic Stability for Survivors of Intimate Partner Violence: Implications for Policy, Research, and Practice." She began her presentation by honoring the vision of Patti Bland (Real Tools: Responding to Multi-Abuse Trauma), whose groundbreaking work on these issues was rooted in the voices of people with lived experience of substance use, substance use coercion, and IPV. Dr. Warshaw's presentation provided an overview of the current state of knowledge about substance

use coercion and IPV, including data from NCDVTMH's substance use coercion survey (conducted in partnership with the National Domestic Violence Hotline), information from the literature review and key informant interview reports generated for this meeting, and results from two recent NCDVTMH surveys: a national needs assessment of domestic violence programs and a national survey of state SUD treatment systems conducted in partnership with the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

Dr. Warshaw noted that while there are a handful of evidence-based practices that address IPV and substance use, none specifically address substance use coercion, marking a critical gap in research and services. She pointed to NCDVTMH's 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, which provides guidance for primary care and behavioral health providers on working with people who experience substance use coercion. Dr. Warshaw also highlighted the barriers survivors face in accessing both domestic violence services and SUD treatment, particularly related to service availability, accessibility, and philosophy, and cited research suggesting that integrated, gender-responsive, trauma-informed services may be uniquely beneficial to survivors of IPV who use substances.

Dr. Warshaw then discussed the implications of substance use coercion for the current opioid epidemic, noting that while trauma, opioid use, and IPV are clearly intertwined, there has been little attention paid to the potential role of substance use coercion in people's use of opioids and in opioid-related deaths—issues that are critical to consider in the development of strategies to address the opioid epidemic. For example, concerns about rising rates of opioid use and overdose among women led to the recognition that women have unique risk factors for developing OUD (US Department of Health and Human Services, 2017). Women who have been diagnosed with OUD are more likely to have experienced IPV, sexual violence, and childhood sexual abuse; are more likely to develop a range of trauma-related health and mental health conditions; are more likely to self-medicate to cope with trauma; and are more likely to have been prescribed opioids for chronic pain. As compared to men, women are also physiologically more likely to become addicted in a shorter period of time and to experience more severe health consequences from substance use. These factors increase women's risk for addiction, medical complications, overdose, and death, all of which are amplified in the context of substance use coercion and IPV. Lesbian, gay, bisexual, and transgender survivors of IPV are also at greater risk for opioid use and addiction (Girouard & The National LGBT Health Education Center, 2018).

Dr. Warshaw then asked participants to think, from both a treatment and public policy perspective, about the potential role of substance use coercion in:

- The initiation into opioid use and subsequent physiological dependence;
- The development of medical complications associated with injection drug use;
- The ability to engage in OUD treatment;
- OUD relapse and recovery;

- Opioid overdose and overdose-related deaths and maternal mortality;
- The development of Neonatal Opioid Withdrawal Syndrome;
- Child welfare and criminal justice system involvement; and
- The ability to maintain housing, educational opportunities, and employment.

Dr. Warshaw suggested that considering the role substance use coercion may play in survivors' risk for opioid use and its attendant complications underscores the need for integrated IPV and OUD services and for coordinated public health responses. Considering the role that substance use coercion may play in survivors' risk for involvement in the child protective services and criminal legal systems (including being coerced into illegal activities or trafficking under the threat of forced withdrawal) is critical to the development of IPV-informed state and federal opioid policy, as well.

Finally, Dr. Warshaw offered recommendations and strategies for addressing substance use coercion that emerged from the key informant interviews conducted in preparation for this meeting. Recommendations include:

1. Improving cross-sector partnerships at the state and local levels;
2. Ensuring that addressing substance use coercion becomes part of the standard of care for substance use treatment and prevention and for opioid harm reduction and overdose prevention initiatives;
3. Increasing access to a comprehensive array of substance use disorder and recovery services—including services that offer medication-assisted treatment (MAT) as well as inpatient, outpatient, and residential options—that jointly address substance use and IPV and that are holistic, gender-responsive, trauma-informed, two-generation, culturally and linguistically appropriate, and fully accessible;
4. Promoting education and training on substance use coercion across all of the systems that impact survivors' lives;
5. Encouraging and supporting research on substance use coercion;
6. Developing strategies to support economic self-sufficiency for survivors impacted by substance use coercion and addressing substance use coercion as part of parenting and economic empowerment initiatives;
7. Addressing the impact of substance use coercion on survivors' involvement with the criminal legal system, including the impact of incarceration on future economic stability as well as strategies to address the role of substance use coercion in child custody decisions and child welfare system involvement.

Dr. Warshaw concluded by emphasizing the importance of centering the voices of survivors who have experienced substance use coercion in the development of policy, research, and programming to address this widespread form of abuse and its far-reaching effects.

PANEL 1: DISCUSSION WITH INDIVIDUALS WITH LIVED EXPERIENCE

The panel featured the powerful voices of three people with lived experience of substance use coercion and other trauma. Panelists provided a deeper understanding of the impact of substance use coercion; articulated the barriers to safety and recovery survivors face; and offered guidance on ways to improve services, systems, and policies.

Panel members included:

- Christina Love, Advocacy Project Specialist, Alaska Network on Domestic Violence and Sexual Assault
- Janette Garcia, Training Manager, Haven Women's Center of Stanislaus, Stanislaus County, CA
- Sara Wilson, Survivor
- Facilitator: Gabriela Zapata-Alma, LCSW, CADC, Director of Policy and Practice for Domestic Violence and Substance Use, NCDVTMH

Gabriela Zapata-Alma, LCSW, CADC explained that the panelists would respond to a series of questions about their own lived experiences with substance use coercion, what they found helpful, the challenges they faced, and their recommendations for improving policy and services for survivors experiencing substance use coercion in the context of IPV and other trauma.

QUESTION #1

What helped you escape substance use coercion and establish stability in your lives?

Christina Love, who is an Indigenous woman from a small village in Alaska, said she had to "go big" before she could "zoom in" with her response. She shared what she learned about and experienced related to the stigma and discrimination associated with mental health conditions in Alaska in the 1960s, the family separation practices used against Indigenous and Alaska Native families, and the generational and historical contexts of poverty and marginalization. She said learning that addiction is a disease was liberating and that access to services, particularly same day access, is critical. Ms. Love talked about myths surrounding the disease of addiction and the criminalization of how people survive (e.g., by using substances). She explained that, in her view, trauma is the major underlying cause of mental health and substance use challenges and that these challenges are community—not individual—problems. She added that she established stability in her life "by coming into contact with people who really listened, who saw me as a human being, and who allowed me to move at the speed of trust," and by "coming into contact with services that transformed to fit me, rather than the other way around." She also talked about the need for a culturally responsive, trauma-informed approach.

Janette Garcia described ways that trauma had impacted her substance use. She shared a story about the connections between trauma, her family history, and her substance use, stating that without drugs to medicate her pain, she would have died by suicide because of her experiences of

being raped. She also said that her abusive partner was her drug connection and it was his substance use coercion that kept her in the relationship for seven years. A Narcotics Anonymous sponsor introduced her to other supports, including domestic violence resources and support groups with women who had similar experiences. When she saw others healing, it gave her hope that she too could heal. A little bit of hope helped her leave her abusive partner for the last time. In addition to support groups, Ms. Garcia shared that financial aid, scholarships, state vocational rehabilitation, parenting classes, church and faith, employment and benefits, the many mentors throughout her journey, and people with a deep understanding of trauma also helped her to establish stability in her life.

Sara Wilson spoke about trauma and her family life, recalling that her father abused her mother so badly that she lost all of her teeth by the age of 25. Ms. Wilson became pregnant after she was raped at a party at age 17. She signed a modeling contract as a way to get out of her small town, but instead was forced into drug use and entrapped into trafficking. When she escaped, she couldn't find any help in her community and Child Protective Services threatened to take her child away. She said her child is what got her though and, if custody had been taken away, she would not be here today: "If you take the child, you take the reason. What helped me was I had my child and I had people that talked love into me—they reminded me that I was human and the trauma was not my fault." Ms. Wilson added that women need to support each other. She was told by others that she went through what she did because she is an attractive woman and that is what happens, but, she said, "it should not happen to anyone."

QUESTION #2

What were the barriers you encountered in your pursuit of safety and recovery?

Ms. Garcia said that in addition to having to deal with poverty, homelessness, and the stigma of addiction, her abusive partner was able to manipulate the very systems that were designed to protect her, increasing her risks while failing to hold her abusive partner accountable. Specifically, she noted that family court proceedings increased her danger by ordering her to participate in parenting classes and mediation with her abusive husband—despite having an active restraining order—and by denying supervised visitation (thus requiring that visitation take place in an unsupervised and unsafe manner). In addition, her husband failed to comply with court-mandated orders regarding child support, so she needed to miss class, treatment, and work in order to secure childcare. He also managed to harass and control her through other systems, including law enforcement, TANF, and family court. Ms. Garcia emphasized that couples counseling is dangerous, particularly if done with clergy or mental health providers who do not understand IPV. Ms. Garcia added that most services were compartmentalized and not trauma-informed, making them difficult to navigate. Finally, substance use treatment itself was coercive and controlling (i.e., being pressured to assert herself and set boundaries in ways that would have escalated her danger and being pressured to share her story with others in the program, many of whom were abusers themselves). Additional barriers included lack of childcare, transportation, and insurance. It took years for Ms. Garcia to secure child support, obtain a divorce, and live in safety.

Ms. Love shared powerful personal stories illustrating the ways systems of care can cause harm. She noted that we cannot talk about single issues because we do not live "single-issue lives." When she was experiencing abuse, she recalled that every system that was supposed to help her caused her harm. She said when she and her sisters reported their father for sexual abuse, she was blamed by the community before her abusive father was finally held accountable and went to jail. She discussed suing the state of Alaska to release her siblings from a psychiatric "institute" where their stay was supposed to be 30 days but actually lasted four years. She spoke of multiple efforts to access services that were rejected for the very reasons she needed those services in the first place. After one particular assault, the police refused to help her because she was addicted to heroin. Her first attempts to access substance use treatment services were unsuccessful because she lacked transportation and proper identification. At that point in her life, she recalls that she did not even have a concept of time. She said, "They thought I didn't want the services." When she was finally able to connect with entry-level services, she encountered a 3-week waiting list for an assessment and a 3-month wait for treatment. Ms. Love said that together, all of these experiences repeat the same message over and over: "'You are not worthy.' We talk about trauma-informed services, but people aren't ready to really deal with what responses to trauma look like. My dad had access to more services and support as a sexual abuser than I did as an addict."

Ms. Wilson talked about being terrified of systems in her community that she feels are stacked against survivors, saying, "You can't come forward and ask for help if you think you're going to be punished." She recalled, "[When I was still living at home], I reported the abuse and the cops told my parents everything. They covered [themselves] and then sent me home and I got beat for two weeks." Ms. Wilson related that, "I have to see the rapist who fathered my daughter every other week because of custody and visitation." She noted that she is in recovery now but if at some point she sought treatment, she would likely lose custody of her child to the child's father. Additional barriers include not being believed and a lack of training for judges and others in the judicial and law enforcement systems. She is now challenging judges who say it is cheaper to lock someone up or take away a child than to provide services. "The menace to society is the refusal to help… we're looking at budgets, not people. We're doing what's cheaper instead of what's effective." Finally, she believes that while prison is not the answer, for people who end up being incarcerated, treatment in prisons needs to improve. "I'm going to bring awareness to where they failed me in the hopes that they don't fail my neighbor."

QUESTION #3

What is needed in order to support survivors experiencing substance use coercion?

Ms. Wilson discussed the importance of across the board national-level training that includes attention to smaller communities. She also shared that it is critical to keep children in the care of their mothers, adding, "That helps a mom recover; you take her child, you take her life."

Ms. Garcia's recommendations included: changing TANF and welfare-to-work programs; adjusting court hours to better serve those who want to obtain an education; improving services by cross-training staff, adding that training must be ongoing; expanding access to domestic violence,

substance use, mental health, and trauma training for courts; instituting mandatory training for attorneys on trauma and memory; improving access to Section 8 housing, as there is currently a 10-year waiting process; ensuring seamless access to services and treatment; fostering collaborative, holistic service provision, including by health care and faith-based organizations; training teachers to recognize signs of trauma and to stop expelling students who act out due to trauma-related behaviors; increasing residential treatment for women and children; and providing more funding for domestic violence shelters.

Ms. Love said research is needed to expand the conceptualization of adverse childhood experiences (ACEs) to include what is happening to people living on the margins, with specific consideration to adverse *community* experiences and adverse *collective* experiences. She said we need to look at history, power, control, and privilege—as violence is a learned behavior—and focus on equity and inclusion. She also said having the ability to report abuse or substance use without fear of prosecution will save lives. Ms. Love spoke about the value of trauma-informed peer support and moving toward healing-informed care. She added that more money is spent on the separation of families than on reunification and that training on trauma, domestic violence, substance use, and sexual assault should be mandatory for everyone in the field, including law enforcement.

QUESTION #4

With the new Family First Prevention Services Act (Family First) going into effect, how do we support good treatment?

Ms. Wilson said making childcare available for people in treatment was critical, adding that she wasn't able to engage in treatment because there was no one to look after her child. "How do you get the treatment? It was: give up my child or do it all on my own." She had no recourse but to pursue the latter option.

Ms. Garcia emphasized the need for treatment provided by people who understand and have empathy. She shared that while she had received a lot of good treatment, she also had a counselor who was inappropriate and who never faced any consequences for abusing their power.

Ms. Love said that celebrating all pathways is incredibly important, including MAT, peer support, and both inpatient and outpatient treatment. She reported that when she was on MAT, her partner would continue to stalk and harass her and that she was able to continue in treatment only because she had access to other treatment alternatives. What is most important is that people have many options.

QUESTION #5

What resource did you wish existed as you were fighting abuse, systemic oppression, and substance use coercion?

Ms. Wilson said she wanted to feel safe, heard, and understood; for someone to understand her and say she was not alone and that she could do it. She said her process could have gone faster, given

what she experienced, if she had had the right support. Every service provider she worked with was a man, which turned out to be harmful.

Ms. Garcia said, "I wanted my daughter to never have to hold her breath and listen to me cry like I did with my mom. I wanted the chain to be broken. I wanted her to have a different life and she does."

QUESTION #6

What is needed in order to support survivors experiencing substance use coercion?

Ms. Love responded, "Absolutely… we can only bring people as far as we've come. We've all got to be doing the work ourselves; because they had done the work themselves, they could be present for me, believe in me, and hold hope for me until I could hold it myself."

Ms. Wilson added, "The people who helped me listened to understand, instead of listening to respond."

GROUP REFLECTIONS FROM THE MORNING

Cathy Cave, Senior Training Consultant, NCDVTMH, urged participants to think about how they can amplify the voices they heard and to write down ideas on the provided reflection and journaling sheets. She also shared NCDVTMH's Tools for Transformation and Organizational Reflection (Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations).

PANEL 2: DISCUSSION ON INTEGRATED AND/OR COLLABORATIVE SERVICES

This panel highlighted a continuum of approaches to addressing the intersections of IPV, substance use, and substance use coercion. Panelists included:

- Angie Pye, CEO, Beacon Center, Volusia County, Florida
- Irene Lindsay Brantley, Program Director, Women in Transition, Philadelphia, Pennsylvania
- Alison Sunday, MSA, Executive Director, Lafayette House, Joplin, Missouri
- Gwendolyn Packard, Training and Technical Assistance Specialist, National Indigenous Women's Resource Center, Albuquerque, New Mexico
- Facilitator: Kenya Fairley, MSEd, Supervisory Program Specialist, Division of Family Violence Prevention and Services, Family Violence Prevention and Services Program

Ms. Fairley began by reviewing the panel's goals: to highlight model approaches to IPV and substance use, with a focus on substance use coercion; to discuss the challenges programs face in

addressing these issues; to share lessons learned; and to consider what could come next to improve services for survivors and their children.

QUESTION #1

Each panelist was asked to talk about how they came to this work, the needs their program was designed to address, how their program evolved over time, and the key features of their program.

Angie Pye, CEO of Beacon Center, said that her work in these intersections began 23 years ago when she watched women come to shelter for safety and then have their children taken from them, adding, "It's heartbreaking that someone could reach out for help and be punished for it." Ms. Pye noted that it is not uncommon in child welfare cases for children to end up in the custody of an abusive partner because the mother has substance use challenges, even though her substance use is primarily a response to trauma. In order to address these concerns, Beacon Center incorporated a harm reduction approach, making it possible for survivors to access services whether or not they were actively using substances. The program's only request was that participants not use or bring drugs or alcohol onto the property. As a result, the program became a safe place for women to talk about their use of substances instead of having to hide it, which in turn created the opportunity for them to safety plan around substance use and substance use coercion. In addition, everything at Beacon House is peer-led, incentive-based, and non-punitive. As these changes took hold, program participants who were in recovery began inviting women who were actively using into their groups, rather than judging or excluding them, an innovation that was very successful. Ms. Pye also made it clear that "We love and care about the people who come into our shelter. We support the choices they make and talk with them about being safe, from a place of caring about them. The more we do that, the more the staff grows, and the more women see us as partners in the process."

Irene Lindsay Brantley, Program Director, Women in Transition (WIT), shared that WIT started out providing divorce and separation counseling, but the work has always been about listening. By listening, they learned about the violence in women's lives and sought funding for domestic violence services. Then WIT learned about the substance use women experienced, which led to their current integrated approach. Ms. Brantley said, "This thin thread of coercion is almost invisible; it was quiet." WIT is a counseling program that does not provide treatment or shelter, but works closely with programs that do. WIT's work is based on a holistic conception of safety—not just physical safety—and on the philosophy that if someone is not safe, there is no way they can plan moving forward. Part of being safe is having control over being safe, which means believing you have the right to be safe, having the tools and resources to be safe, and having the support systems in place to be safe. WIT does not prescribe medication. There is no sobriety requirement, no shame or guilt, and no process of "breaking people down to build them up." WIT works to support people in being safe, based on what being safe means to them.

Alison Sunday, Executive Director, Lafayette House, said that Lafayette House opened in 1978 when a group of domestic violence survivors decided Joplin, Missouri needed a safe place for women who needed to leave violent relationships. Lafayette House has been peer-led ever since. In 1985, Lafayette

House had an opportunity to listen formally to what women walking through their doors wanted and needed. It was jarring to hear so many women talk about how they survived by using alcohol, only to discover that alcohol became part of the problem. Lafayette House recognized the two issues—violence and substance use—as linked and saw it as their responsibility to provide the necessary resources. The initial service delivery model was a sequential one: safety from domestic violence first and then substance use disorder treatment. Becoming part of the Substance Use and Mental Health Services Administration (SAMHSA) Women, Co-Occurring Disorders and Violence Study in the mid-90s led to the implementation of a more holistic, integrated, trauma-informed approach. Currently, Lafayette House supports a residential treatment program for women and dependent children with on-site daycare, a domestic violence shelter, and transitional housing. Ms. Sunday added that an empowerment model is critical to their work: "We share what's available but you choose what services you want and when to receive them."

Gwendolyn Packard, Training and Technical Assistance Specialist, National Indigenous Women's Resource Center, offered a broad perspective in her presentation, laying the groundwork for thinking about substance use and substance use coercion in the context of violence against Native women. She began with the point that Indigenous people are very diverse. There are 574 federally-recognized tribes in the US, in addition to a number of state-recognized tribes, and over 6 million Native people in the US, comprising 2% of the population. Of that population, 70% live off-reservation. Each tribe is unique. "We are all sovereign nations, with complex jurisdictional issues that create a multitude of challenges for each of us." These jurisdictional issues compound the risks for Native women, who have the highest rates of domestic violence, sexual violence, stalking, and trafficking in the US, in addition to large numbers of Native women who are missing and murdered. She said, "Not having laws that protect us makes us the perfect target." In addition to the high rates of violence against Native women, there is also a serious lack of resources for survivors in Native communities. Most people would seek resources if they were available, she said, but they are just not there. For example, there are fewer than 45 tribal domestic violence shelters in the US. For 38% of people in Native communities, there are no substance use resources or treatment centers and for a number of years, there were no inpatient treatment facilities.

Ms. Packard then spoke about the innovative healing work done in Native communities and the ways communities are incorporating Indigenous thinking and traditional practices into their programming. Healing practices include:

1. **Being Holistic:** Being holistic means not just looking at domestic violence and substance use as separate issues, but recognizing that everything is connected and intersectional. "We are not single-issue people. We have learned, we have lived, and we have grown up dealing with all of these intersections and understand how they connect."
2. **The Importance of Ceremony:** Ms. Packard shared that she had "learned about the importance of ceremony and tradition from our spiritual advisors and people with a very different mindset" when she was doing mental health work. She said, "In our society, people with mental health issues are considered to have a special gift. They are honored and supported and there are ceremonies to connect the body to the spirit when they become disconnected." Ceremonies

to bring back the spirit are "powerful medicine." For people with mental health conditions, experiencing stigma, judgment, and lack of resources is very different from being supported and taken care of.

3. **Everything is Connected and We Are All Related:** Ms. Packard highlighted the work of Tillie Black Bear, founding grandmother of the movement to end violence against women, who taught us to treat each other as good relatives and to recognize that we are all related to each other.
4. **Everyone Has a Song:** We all have value and bring something to the table. Everyone has a gift. What is important is bringing out that gift in each other.
5. **Harm Reduction as a Way of Life:** Although harm reduction has a different meaning now, harm reduction has always been our way of life. Working with people where they are, without judgment or stigma, is how we keep our communities safe.
6. **Resilience:** Ms. Packard ended by saying, "We are an extremely resilient people for all that we have experienced in last 500-800 years. Our communities have very little. Many do not have running water or electricity, let alone healthcare or treatment facilities. And, despite those odds, we continue to grow and thrive as a people. That we are still here—all 6 million of us—clearly speaks to our resilience."

QUESTION #2

How does your program address the unique needs of survivors experiencing substance use coercion?

Ms. Brantley said that the first thing WIT does is ask "Why did you call today?" Program staff then listen to figure out the best way to move forward. An intake or assessment is not "one and done"—it is the beginning of a process that evolves over time. For example, a person may come in for domestic violence and not disclose that they are using substances. Later we might find out that they were blaming themselves for the abuse because of their substance use. Substance use coercion is not something people necessarily know about when they call. She noted that "It's more a matter of listening with an opportunity to educate about what we're hearing." She also stressed that relationships change, life is complicated, and there is no cookie cutter approach. Listening, being present, and working with each person based on where they are in their own process are key. In addition, WIT has a strong peer support focus and peers will often pick up on what is missed in a group setting. The program also holds groups in other settings, including inpatient and outpatient treatment programs, creating additional opportunities to make links between people's experiences of substance use and domestic violence, and to meet more people where they are. Finally, Ms. Brantley emphasized the importance of self-care for staff, including spending time processing what they are working on and hearing, noting that staff are going home with people's stories, as well as their own.

Ms. Sunday also noted that most women who come into Lafayette House do not recognize the substance use coercion aspect of the abuse at first. Staff focus on listening to a woman's story and affirming that they believe her. If a woman starts to recognize power and control dynamics in her relationship, it is her own revelation. "We do hear the fear associated with substance use coercion.

Women will talk about how their abusive partner will use it against them in court ('You are trash and no judge is going to listen to you. When I tell them how you shoot up regularly, it is over'). In fact, the hook for most of the women we work with is the fear of losing custody of their children. It is so easy to believe that tale, and unfortunately it is true. The courts are very punitive to women who use substances, at least in [her local area]." Over the years, the program has strengthened its advocacy services so women are not going to court by themselves. Ms. Sunday noted that staff go home with those difficult days, especially if they themselves have had similar experiences. For example, when the courts are punitive to a woman because of her substance use. She also stressed that dealing with secondary trauma is critically important.

Ms. Sunday also responded to a question about Lafayette House's experience providing services under the Family First Act. She reported that as part of Family First in Missouri, Lafayette House is one of seven CSTAR-certified programs for women and children and is funded by the state to provide gender-specific treatment. When Family First was adopted in Missouri, they came to Lafayette House because it was the known trauma-informed program and asked if they would model this treatment program. She shared that "If the Children's Division needs to take custody of a child, instead of placing them in temporary foster care or in a facility, they place the child with us. This allows the mom to obtain treatment and services while retaining physical, but not legal, custody." They only have two women in the program now and, so far, they have had tremendous success. She reported that "When the first participant's child was born positive [for drugs], the state placed her and her infant in our facility. She has done so well that her 3-year-old, who she had never previously had physical custody of, has now been placed with her. She is now in our transitional housing and the children's division staff are celebrating her positive experiences."

Ms. Pye reported that most of the survivors who came to Beacon Center felt responsible for the violence because they were using, even if they were being forced to use. For many survivors, the abusive partner is also their drug dealer. When they do assessments, they start with, "Tell me about the day you met this person, what was it like in the beginning?" They work with women on identifying how their partner uses substances to further penalize them and on recognizing those behaviors as part of the coercion. They know abusers will continue to engage in tactics that work, so staff try to prepare participants for that. Ms. Pye expressed concern about 12-step programs that ask people to take responsibility for what is happening to them: "With domestic violence, it is dangerous to believe that the person being victimized is at fault because of their drug use. We make sure to let survivors know the abuse is not their fault regardless of their use of substances." Finally, Ms. Pye highlighted some of the community capacity-building initiatives they have adopted to deal with these issues, including working with their probation, parole, and child welfare systems to prevent abusive partners from leveraging those systems against their partners. For example, when a survivor is on probation for substance use, it is not uncommon for the abusive partner to entice her into using with him and then call her probation officer, knowing it will land her in prison. These efforts include working with the courts to divert survivors to treatment, working with judges to ensure survivors can come to Beacon Center prior to release so they have a safe place to go, and working with child welfare to support survivors when their abusive partner tries to create barriers to make their case go awry.

QUESTION #3

How do you measure success? How do you define success? Is your definition different than your funders?

Ms. Pye stated that she has no doubt that her definition of success is different from her funders. She defines success as the number of people who stay in the program and are successful in getting their needs met in a safe way. In addition, Beacon Center found that 60% of their participants did not relapse in the time-frame they were involved in the program or over the next year. She also noted that relapse is part of the recovery process. They also found that people who did relapse were talking about it and taking steps to be "back on the path."

Ms. Sunday stated that everything in their programs is measured in terms of safety. Lafayette House does a 90-day post-discharge call, asking questions such as: "Are you still safe? Is your house safe? Do you need resources to be safe?" Safety is looked at in many different ways.

Ms. Brantley said that WIT had just started using MOVERS (Measure of Victim Empowerment Related to Safety), a 13 question pre- and post-assessment used by clients to rate how they feel about certain areas of safety. By implementing MOVERS, the program hopes to be able to provide funders with some quantitative data.

After the panel, meeting participants were asked to consider and note their reflections on the day, and then each table discussed the following questions:

- How does the information presented so far relate to your agency and your agency's mission?
- What are some ways that your agency is already addressing some of the concerns or recommendations mentioned so far?
- What culturally-responsive approaches or services does your agency currently utilize?

Topics reported back to the larger group included: defining and explaining what substance use coercion is and how it fits with prevention, training for healthcare providers on substance use coercion, and the need for direct service and treatment programs to give people the space to "be human."

PANEL 3: DISCUSSION ON RESEARCH NEEDS

This panel provided an overview of the current state of research on substance use coercion, highlighted critical research gaps, and offered recommendations for expanding research on IPV, substance use, and substance use coercion.

Panelists included:

Eleanor Lyon, PhD, Senior Research Advisor, NCDVTMH

Emily Rothman, ScD, Professor, Boston University School of Public Health

Louisa Gilbert, PhD, Associate Professor, Columbia University School of Social Work

Neeraj Gandotra, MD, Chief Medical Officer, Substance Abuse and Mental Health Services Administration (SAMHSA)

Facilitator: Laura Erickson, MPP, Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation (ASPE)

Ms. Erickson introduced the Panel Discussion of Research Needs speakers.

Research Panelist Presentations

Eleanor Lyon, PhD, Senior Research Advisor, NCDVTMH, presented *NCDVTMH Research on IPV, Substance Use, and Substance Use Coercion: Current and Ongoing Work*. The talk provided an overview of findings from two NCDVTMH national needs assessments and updates on two NCDVTMH substance use coercion-related tools. Dr. Lyon first shared findings from NCDVTMH's national Domestic Violence Program Needs Assessment Survey, which was conducted from June to September 2019 with 579 participants from domestic violence programs within states, territories, and tribal nations across the US.

Key findings included the following:

- 74% of domestic violence programs reported an increased demand for substance use services over the past two years;
- 51% reported changes in the kinds of substance use they saw in their programs, with 56% reporting an increase in opioid use and 37% an increase in methamphetamine use;
- Only 20% of domestic violence programs felt 'very prepared' to support survivors who use substances, and even fewer (17%) felt prepared to meet the needs of survivors struggling with substance use who are also parenting.

The top three resources wanted by domestic violence programs were:

1. Expedited referrals for substance use disorder treatment;
2. Training for staff on domestic violence, trauma, and substance use; and
3. Funding for more on-site substance use services (Phillips et al., 2020a).

Dr. Lyon also shared findings from the Survey of State Substance Use Disorder Treatment Systems, a partnership between NCDVTMH and NASADAD. This survey was conducted from May to August 2019 with representatives from 26 states and territories. Key findings included the following:

- Half of respondents reported some level of partnering with domestic violence agencies and offices within their state/territory (19% reported solid partnerships, 31% limited partnerships);
- Collaboration most often occurred with offices responsible for domestic violence funding or with state/territory domestic violence coalitions;
- Major barriers to cross-sector partnership included limited capacity, resources, time, and

funding, as well as legislative mandates and policies that lead to "siloed" services;

- 88% of state/territory opioid plans do not address domestic violence;
- 64% of states/territories do not have requirements for addressing domestic violence in substance use treatment and/or recovery services;
- Fully 48% of respondents, however, indicated that their state/territory requires some manner of domestic violence-related training as part of workforce development.

In several states/territories, domestic violence and substance use are jointly addressed. Suggestions for increasing access to co-located and integrated models included: decreasing barriers to accessing services (including transportation), supporting funding requirements that focus on screening and treatment for domestic violence in substance use disorder treatment settings, and increasing cross-training on substance use and domestic violence.

Dr. Lyon also shared that the Substance Use-Related Coercion Scale is in a late phase of development and discussed plans for testing NCDVTMH's *Toolkit on Coercion Related to Mental Health and Substance Use in the Context of IPV*.

Emily Rothman, ScD, Professor, Boston University School of Public Health, presented *Recovering in Safety* and discussed a research project funded by Robert Wood Johnson Foundation examining opioid use and IPV in Vermont. She began by highlighting that Vermont is "number one" in terms of illicit drug use in the US and that opioid-related deaths (primarily heroin and fentanyl) are a serious problem. Part of what inspired this project was learning that in the small domestic violence shelter where Dr. Rothman used to work, five women had overdosed on opioids during the previous year, yet the people who worked in the shelter had no specific training on substance use. In addition, Vermont's recovery coaches have no training on trauma or domestic violence. She shared that women who need recovery housing are turned away because they are in danger from abusive partners; programs are concerned that this situation may place others in danger. As Dr. Rothman said, it was clear that something needs to be done. The research is structured as a community partnership, with an advisory board that includes three women with lived experience of IPV and opioid use disorder who vet everything they do. The project has three phases: 1) conducting a needs assessment, 2) designing and implementing an intervention, and 3) evaluating the intervention. Dr. Rothman reported on some of the findings from their qualitative interviews. She said that what they heard over and over is that people get trapped; it's both difficult to get out of the relationship and to access treatment and recovery. For many, children are a major motivator. Dr. Rothman provided a list of system-level issues that need to be addressed, including: lack of transportation, social and geographic isolation, challenges related to changing one's support network in small rural communities, stigma, lack of services for both partners, lack of long-term recovery care, discharge planning that is not trauma-informed and does not include safety planning, and the lack gender-specific support groups.

Louisa Gilbert, PhD, Associate Professor, Columbia University School of Social Work, talked about the prevalence of gender-based violence (GBV) among women using drugs (WUD), and pathways

linking GBV to substance use. Research has used very limited descriptors for partners (e.g., boyfriends, husbands), which is one of the reasons rates of IPV are consistently underestimated. Dr. Gilbert referenced the 1996 Power and Control Model for Women who Use Drugs, adding that despite research validating the prevalence of substance use-related IPV and coercion, these issues have not been integrated into standard IPV screening tools for WUD and they have not been regularly addressed in substance treatment or harm reduction programs. She also discussed a recent study demonstrating the intersection of law enforcement, IPV, and WUD. There are high rates of violence by police against WUD. Notably, fear of police is a major barrier, especially for Black women, when it comes to seeking help for IPV and substance use. Dr. Gilbert pointed to the challenge of linking the more than 90% of WUD who experience IPV and are not receiving IPV services, and talked about where to start: community corrections, emergency care, peer outreach to hot spots, and child welfare. Dr. Gilbert discussed the importance of multi-level integrated interventions focusing on IPV and GBV, substance use, and trauma. She also described a program she developed called Women Initiating New Goals of Safety (WINGS), a screening, brief intervention, and referral to treatment (SBIRT) model to address IPV and GBV among WUD, adding that what is needed is a community-level system change response to this epidemic.

Neeraj Gandotra, MD, Chief Medical Officer, Substance Abuse and Mental Health Services Administration (SAMHSA), noted that many of the issues in his past work echoed those discussed at this meeting, including barriers to care and concern for children. Dr. Gandotra talked about the way addiction isolates and about structural barriers to seeking care, such as inadequate health insurance and limited access to transportation. He discussed the benefits of effective coordinated and co-located services, shared a list of resources and publications, and discussed the SAMHSA Technology Transfer Centers (TCC) for addiction, mental health, and prevention, as well as grant opportunities. He highlighted areas in which more research is needed, including: the impact of patient/client trauma histories on providers delivering trauma-informed care; outcomes on social determinants of health; prevention outreach to family members; and modifying approaches to treatment to increase awareness of cultural differences when considering the dynamics of coercion and approaches to treatment.

QUESTION #1

What are each of your thoughts regarding the gaps in research related to IPV and substance use and, more specifically, substance use coercion?

Dr. Gilbert emphasized the need for implementation research, given that there are already worthy interventions "on the shelves." Such research can provide valuable insights about multi-level community and structural barriers and about designing and delivering interventions so that people can access IPV services and substance use treatment in ways that best meet their needs.

Dr. Gilbert added that we need to go upstream to community-level intervention and figure out—in a data-driven, research-savvy way—how to create the systems change needed to sustain good programs.

Dr. Rothman noted that most of the funding available for opioid and substance use prevention goes to hospitals and the medical system; however, it is important to remember there are other parts of the community where people make differences and where opportunities are missed when resources are not equitably distributed.

Dr. Lyon suggested that we incorporate questions about substance use coercion into other research where related information is collected to gain a better understanding of drug-related sexual violence and coercion. Examples include national surveys such as the Centers for Disease Control and Prevention (CDC) National Intimate Partner and Sexual Violence Survey (NISVS), the CDC's Behavioral Risk Factor Surveillance System (BRFSS) survey, and SAMHSA's National Survey on Drug Use and Health (NSDUH), as well as research conducted through National Institute on Drug Abuse's (NIDA) Clinical Trials Network. She also advocated for increased prioritization of qualitative research to better understand the impact of substance use coercion and the effect of integrated services, as well as to contextualize ongoing research with regard to social, racial, and economic disparities.

Participant Q & A with Research Panelists

What resources do you know of for programs to become co-located?

Dr. Gandotra said that any mental health or substance use program could offer domestic violence services at the same location and still qualify for SAMHSA grants.

Question about the Intersections between IPV, Substance Use Coercion, and Traumatic Brain Injury

Rachel Ramirez, LISW-S, Training Director, Ohio Domestic Violence Network (ODVN) talked about their research on unidentified traumatic brain injury (TBI) and strangulation among survivors of IPV and asked about how TBI fits into this very complicated landscape. She also shared that they had asked about mental health, substance use, and physical health coercion in their study and found the rates to be incredibly high.

Dr. Gilbert replied that given recent IPV and opioid research, it is spot-on to focus on this; we do not know how brain injuries and opioid use are related.

Questions Regarding Dr. Gilbert's IPV SBIRT Model (WINGS)

Another meeting participant asked about SBIRT training and if there are any plans for adapting it for healthcare providers who have more limited time with patients.

Dr. Gilbert responded that there is a computerized self-paced version of WINGS that covers the same core SBIRT components as the facilitator version and has been found to be equally effective in identifying different types of IPV, increasing IPV self-efficacy, and increasing social support and

access to IPV services. She also stressed the importance of having self-screening tools for people who do not want to disclose their experiences of IPV to a provider. The implementation manual can be downloaded from www.projectwings.org. She also mentioned that in 2015, the United Nations Office on Drugs and Crime (UNODC) issued a recommendation that all harm reduction programs screen for IPV. Organizations cannot understand the scope of the problem unless they routinely screen.

Dr. Gandotra asked Dr. Gilbert if her SBIRT intervention had been Medicare-approved yet. He noted that once it is Medicaid/Medicare-approved for reimbursement, half of the barriers to its use will disappear.

Discussion about Where Opioid Research Money is Channeled

The group revisited the conversation about how the majority of resources are funneled through medical institutions. Meeting participants echoed the need to redefine what we view as healthcare and healthcare settings: any place that can improve people's health is a healthcare setting, including community-based programs.

Question about Stigma

Gabriela Zapata-Alma noted that the group had heard a lot about stigma and the harm it causes to people who experience abuse and people who use substances, especially if they are pregnant or have children in their care, asking what is necessary to truly combat stigma, beyond a billboard or awareness campaign?

Dr. Rothman said this is an area where public health has had some successes.

Dr. Gilbert noted that the HIV movement is breaking down stigma at every level.

Dr. Gandotra suggested that engaging celebrities in efforts to combat stigma can also be effective.

Ms. Love added, "If you're going to change public policy, you've got to change public opinion; first comes the education, [and then] expanding and talking about this again and again for those who will listen and those who will not."

GROUP REFLECTIONS ON NEXT STEPS AND PRIORITIES

Ms. Cave led the group through a grounding exercise that brought attention to each of the five senses.

Ms. Fairley then asked meeting participants to use their journaling sheets to reflect on what they had heard over the course of the day, to consider new potential partnerships, and to identify priorities that we could all work toward.

DAY 1 CONCLUDING REMARKS

Kelly Kinnison, PhD, Director of Family and Community Policy Division, ASPE, offered concluding remarks. Reflecting back on what she had heard throughout the day, Dr. Kinnison said it was clear that substance use coercion is a substantial policy issue that cuts across HHS programs and initiatives and severely impacts survivors and their children. She shared that a major focus for ASPE right now is on economic mobility and family stability, including the formation of a new US Interagency Council on Economic Mobility. She committed to bringing issues related to substance use coercion to that agenda. She told participants that she heard how substance use coercion harms survivors' social networks—not only through isolation by an abusive partner but also due to stigma surrounding IPV and substance use, especially for mothers. She noted the connections to ASPE's work on the importance of social networks. Dr. Kinnison said she also learned how multiple traumatic experiences can impact health and well-being and the importance of thinking about IPV and substance use through the lens of lifetime trauma. Finally, Dr. Kinnison spoke of the range of needs and opportunities that she would take back to her agency, including the need for better training and collaboration between domestic violence and substance use providers and systems; the need for integrated, trauma-informed services for women and children; and the need to bring representatives of the healthcare, criminal legal, child welfare, and trafficking prevention and services systems to the table. She said she would do her best to make happen. She also highlighted some of the potential ways that research can help us respond to substance use coercion, including implementing what we already know about identification and response, conducting research that addresses these issues at the community and systems levels, and looking at peer support approaches.

Day 2: October 25, 2019

WELCOME AND DAY 1 RECAP

Ms. Fairley welcomed the group, including some new faces, and thanked Day 1 participants for the ideas and suggestions offered on the submitted journaling sheets, which were reviewed and compiled to help guide Day 2's conversation.

Dr. Warshaw thanked everyone for their presence and for the thoughtful and heartfelt panels that allowed the group to deepen and enrich the evolving conversation about how best to address the complex and intersecting issues of IPV, substance use, and substance use coercion. She thanked the members of the Lived Experiences Panel for delivering such impactful presentations and for their courage, wisdom, and passion; the Integrated Services Panel for their innovative work and commitment to listening to and learning from survivors; and the Research Panel for the rich and informative discussion about the critical research issues that await exploration.

Dr. Warshaw noted that work on substance use coercion is, by its very nature, intersectional and highly contextualized; that experiences of substance use coercion are embedded in many other experiences of trauma; and that understanding of substance use coercion, stigma, trauma, and marginalization need to be infused into all the systems that impact the lives of survivors and their children.

Ms. Fairley shared a summary of reflections from Day 1, asking participants to consider:

- What can be learned from current programs that address one or more aspects of IPV, substance use, and substance use coercion?
- What currently available models work best and why?
- How can current services be improved and/or new services be developed and scaled to best benefit survivors and their children?
- What research questions and priorities need to be addressed?

Ms. Fairley also highlighted a number of additional reflections shared by participants, including the importance of acknowledging the many barriers survivors face when attempting to access services, addressing the holistic needs of survivors and their children, and involving survivors and community members as critical partners in the development and implementation of research.

INTRODUCTION OF THEMES

Day 2 discussions, which integrated insights generated from Day 1, led to the development of recommendations on three interrelated themes:

1. Improving services
2. Reducing stigma, barriers, and harms
3. Developing and implementing a research agenda

Throughout the discussions, the importance of centering the voices and experiences of people with lived experience of IPV, substance use, and substance use coercion was emphasized.

Theme 1: Improving Services

Panelists and participants shared their thoughts about what improving services might look like. Based on this discussion combined with Day 1 reflections, **Ms. Fairley** posed the following questions for discussion:

1. What kinds of services might be most helpful for people experiencing IPV who are using substances and/or experiencing substance use coercion? What elements or features should be included in these services and how should they be offered or delivered?
2. Who is (and is not) currently able to access services? Why are some survivors unable or reluctant to access available services? What opportunities exist (or should exist) for making services available at other points of entry? How can outreach be improved?
3. How can integrated service models become more available, better supported, and scaled to need?

Dr. Gilbert urged participants to begin addressing these questions with a big picture vision of what service improvement would look like in the long term. From that vision, Dr. Gilbert said, we can determine the best models for developing and delivering integrated services for survivors who use substances and experience IPV. Panelists and participants agreed and added that input from people with lived experience, including people not currently accessing services, is critically important in developing new or expanded services.

QUESTION #1

What kinds of services might be most helpful for people experiencing IPV who are using substances and/or experiencing substance use coercion?

Ms. Love emphasized that services should meet people where they are and welcome people as they are, especially when considering the needs, priorities, and vulnerabilities of people who have experienced poverty, homelessness, and racial discrimination. A number of participants urged that attention should be paid to the physical and cultural environment in which services are delivered to ensure they are welcoming to the people being served.

Panelists and participants emphasized that in addition to being easily available and accessible, programs should be inclusive, holistic, integrated, non-punitive, and should incorporate peer support and harm reduction approaches. Ms. Love said that holistic programs "celebrate all pathways or life choices and support empowerment-based treatment where people are able to decide or choose treatment options that work best for them and their children and for their current lives and lived experience." Ms. Love added, "As a person who has navigated homelessness, [it is challenging to] try to do counseling in a place that feels foreign. From poverty to middle class is totally different language. I have been out of incarceration, homelessness, [and] addiction for a decade. There were things I knew early on that I don't know anymore. I have come to a different place where I can sit here with all of you."

Participants agreed that services should explicitly address substance use coercion, given its prevalence and the barriers to safety and recovery it creates. **Dr. Gilbert** said, "If we don't tackle that, we won't see treatment that addresses these issues." She noted that, early in her career, she would see IPV survivors being discharged from treatment for not being able to comply with program requirements (e.g., maintaining sobriety or keeping regular appointments) because of substance use coercion.

A number of participants reiterated the need for programs to embrace peer support and harm reduction models. Dr. Gilbert added that harm reduction approaches are especially important because relapse should not result in someone getting thrown out of treatment.

Ms. Wilson added that love is the key, as love is neither stigmatizing nor punitive. She stated, "Women coming to us need love."

QUESTION #2

How can we best reach survivors of IPV who use substances who are not accessing services?

Panelists and participants agreed that the majority of survivors they have encountered in their communities, services, and research who use substances have also experienced violence, trauma, and substance use coercion. Yet most are not accessing services. Dr. Gilbert reported that in her research, 90% of women who use drugs and experience IPV access neither domestic violence services nor substance use treatment directly; they are more likely to be seen in emergency rooms, jails, prisons, and homeless settings. Participants discussed reasons that survivors may not access services, including scarcity of available services in some communities, lack of awareness that services exist in areas that have available services, being dissuaded or prevented by abusive partners from seeking help, and perceiving shelters and domestic violence agencies to be unhelpful or even unintentionally harmful.

Informed by these observations, participants agreed in order to increase services for those who can benefit from domestic violence supports as well as substance use treatment, the priority should be developing and delivering services that are aligned with people's lived experience, designed to reach people "where they are," and that integrate substance use treatment with domestic violence advocacy and supports.

Participants also highlighted the need to enhance and expand outreach to people in community, carceral, community corrections, child welfare, and homeless settings, including through the use of peer navigators.

Domestic violence advocates can partner with state funders and policy makers to expand outreach through the use of harm reduction strategies, including distribution of naloxone by domestic violence programs, healthcare providers, and behavioral health providers.

QUESTION #3

How can integrated service models become more available, better supported, and scaled to need?

Participants highlighted the importance of supporting an array of integrated service models, including fully integrated models that provide domestic violence and substance use services under one roof, models that offer co-located domestic violence and substance use services, and models that involve close coordination and cross-referral between domestic violence and substance use service and treatment providers. All provide an array of services for survivors in recovery, including job training and placement, housing, legal advocacy, services for parents and children, and healthcare. Models highlighted by participants also have strong peer components and incorporate a harm reduction approach. Many survivors who sought help initially in integrated residential programs continue on with supportive contact when living in community.

Three panelists from Panel 2: Integrated and/or Collaborative Services (Angie Pye, Irene Lindsay Brantley, and Alison Sunday) reiterated the history, key components, and track records to date of the integrated approaches in which they play key roles. **Ms. Dawson** then described an additional promising model in Ohio. Each of these four examples embodied understanding and responsiveness to the complex and intersectional connections between IPV, substance use, substance use coercion, and trauma, emphasizing how these experiences are so deeply intertwined in survivors' lives. Participants emphasized that for services to be fully responsive to survivors' needs, they need to welcome survivors in their full humanity—wherever they are in their own life.

Beacon Center (Volusia County, Florida): Beacon Center's (BC) mission is to provide quality trauma-informed, empowerment-based services to survivors of domestic violence while working with community partners to ensure safety and justice for all survivors and their children. Residential and community-based services include emergency shelter, advocacy, support groups, information and referral services, case management, court accompaniment, safety planning, and other needed services to support survivors in their efforts for safety and well-being. BC's work with women experiencing substance use and substance use coercion is peer-led and embraces a non-judgmental, harm reduction approach, acknowledging the reality of relapse for women who use substances and experience substance use coercion in the context of violent or abusive relationships.

Women In Transition (Philadelphia, Pennsylvania): Women In Transition (WIT) is an integrated program that provides empowerment-based counseling, advocacy, and peer support for people experiencing both substance abuse and domestic violence. WIT does not provide formal substance use disorder treatment itself, but rather works closely with trusted community-based treatment providers that do. WIT also provides onsite domestic violence support groups in substance use disorder treatment settings and engages in community outreach and education activities related to these intersecting issues. WIT's focus in on supporting women to achieve their own goals for safety and recovery in ways that are most meaningful to them.

Lafayette House (Joplin, Missouri): Lafayette House (LH) is a fully-integrated domestic violence, sexual assault, and substance use program offers a wide range of trauma-responsive services, including emergency crisis care, shelter and transitional housing, as well as residential and intensive outpatient substance use treatment, maintenance, and aftercare. Anyone who enters the program has access to a full range of services and develops an individualized plan that addresses their specific needs (e.g., domestic violence, sexual assault, substance use). In addition to MAT, LH offers a wide range of support services including court advocacy, transportation, child care, educational and parenting classes.

Partnering for Family Success (Cleveland, Ohio): Ms. Dawson described an innovative integrated program that has the potential to serve as a model. This program, Cuyahoga County Partnering for Family Success in Cleveland, Ohio, is run jointly by the Departments of Housing and Child Welfare. A community-based integrated domestic violence program has taken the lead to coordinate services from child welfare, substance use, mental health, and youth serving programs, with the goal of preventing removals of children from families and subsequent foster care placements. This program has partnered with Case Western Reserve University to research its outcomes and is planning to release a study in 2020. Ms. Dawson reports that the program's preliminary data are compelling: by delivering integrated services, the program has reduced child removals by 85%. This initial finding is especially relevant because a large proportion of Ohio children at risk for foster care placement are children of color, low-income children, or children who live in rural areas. The program has relied on private foundation funding using a "pay for success" model, in which it plans to repay funders based on savings realized from decreased foster care. Over the past four years, the program has saved $4 million and is well on its way to repaying the full $5 million philanthropic investment that was made.

Participants agreed that all four programs described, while different, have promising features, and that going forward, there is a need for research and evaluation to define best practices for integrated services for survivors who use substances.

Theme 1: Recommendations for Improving Services

Recommendations to improve services generated by participants were centered on the key principle that strategies need to be driven, developed, implemented, and evaluated *in partnership* with people who have lived experience. Participants reiterated that services need to welcome people "as they are," without expecting people to meet externally-imposed requirements they are unable to meet. Participants also emphasized need for a flexible, comprehensive, holistic array of options and services.

As the Day 1 Lived Experience Panel underscored, the insights and leadership of people with lived experience of IPV and substance use coercion are critical to driving change in policy and practice. People with lived experience are knowledgeable about the barriers they themselves faced as survivors, including poverty, homelessness, and the stigma associated with addiction. They have the experience to help guide policymakers and providers in crafting initiatives that can help other survivors overcome similar barriers. In short, their voices *must* be at the table.

With these guiding principles in mind, Theme 1 recommendations include the following:

Develop and Implement Integrated, Co-located, and Coordinated Domestic Violence and Substance Use Services

- Work with survivors and researchers to identify best integrated services models for people who use substances and experience IPV.
- Provide support to community-based domestic violence programs to help them create and make available a range of integrated service delivery models that honor the voices of survivors experiencing substance use and substance use coercion, and incorporate a culturally-responsive harm reduction approach.
- Provide support to culturally-specific and Indigenous domestic violence programs to develop and implement models for responding to survivors who use substances.
- Assist domestic violence program efforts to create and integrate peer support models into their residential and community-based programming. This includes supporting the development of partnerships with peer recovery organizations such as the Faces and Voices of Recovery Movement to develop integrated IPV/peer recovery approaches.
- Acknowledge and incorporate an understanding of complex relationships between child removal, poverty, education, housing, violence, racism, and social injustice.
- Incorporate trauma-informed, two-generation approaches that support parent-child attachment and healing.

Incorporate IPV and Substance Use Coercion into Substance Use Prevention and Service Delivery Initiatives

- Incorporate information and resources about IPV and substance use/substance use coercion into SAMHSA-funded mental health and substance use services as well as Pregnant and Parenting Women (PPW) programs.
- Introduce substance use coercion and IPV priorities into programs and services funded by the Comprehensive Addiction Recovery Act (CARA).
- Support the development of best practice guidelines for responding to IPV, substance use, and substance use coercion for federally funded substance use disorder treatment providers.
- Encourage collaboration between state, territory, and tribal domestic violence coalitions; state FVPSA administrators; and state substance use administrators to develop more integrated approaches to IPV, substance use, and substance use coercion at the policy and practice level (For more information, see: Information Memorandum from SAMHSA and ACF Calls for Collaboration on Domestic Violence, Substance Use, and Mental Health).
- Promote the inclusion of state domestic and sexual violence coalitions and state FVPSA administrators in state opioid task forces.

Provide Direct Support to Domestic Violence Programs to Improve Services for Survivors Who Use Substances

- Support domestic violence and integrated program efforts to hire attorneys and legal advocates to help navigate child welfare laws and regulations and to develop strategies to decrease the risk that survivors who are dealing with substance use and IPV will have their children removed into the foster care system.
- Increase funding to support longer domestic violence shelter and transitional housing stays for survivors experiencing substance use coercion and their children.

Support Advances in Policy, Education, and Training

- Promote training and technical assistance for domestic violence programs on working with survivors who use substances.
- Promote training on the intersections of IPV, substance use, and substance use coercion for health, mental health, and substance use disorder treatment and recovery support providers and academic training programs.
- Promote education and training for law enforcement personnel and for judges and court staff, including in small towns and rural jurisdictions, on substance use coercion.
- Build partnerships with child welfare systems to ensure they include domestic violence experts, programs, and advocates in culturally relevant decision making whenever domestic violence is involved.
- Explore opportunities for building partnerships between domestic violence programs and specialized drug courts to support survivors' efforts to access the resources they need to maintain custody of their children.
- Develop programming for youth who are aging out of the foster care system and who are now parents.

Theme 2: Reducing Stigma, Barriers, and Harms

Panelists and participants continued the discussion by sharing their thoughts about what reducing stigma, barriers, and harms might look like. Two focus areas emerged in the discussions:

- **Service barriers and harms**, such as not being able to access services and the services themselves being harmful, and
- **System barriers and harms,** such as systems of care that work against survivors and play into the hands of people who abuse their partners.

SERVICE BARRIERS AND HARMS

Over the course of the meeting, it became clear from testimony offered by people with lived experience, program experts, and researchers that many survivors experience services as harmful rather than helpful. Arising from this observation, panelists and participants agreed that a critical question moving forward is, "How do we address the barriers and prevent or ameliorate the harms that many survivors experience when they do try to access services?" As Ms. Love related during Day 1, "All of the systems that were supposed to help me caused harm."

Ms. Love stressed the importance of ensuring that all tools used in screening for treatment eligibility and service retention are equitable, inclusive, unbiased, and do not themselves cause additional harm. Specifically, Ms. Love urged that the tools used for intake must not screen people out of the very services they seek, stating, "It's so important that everything is approved by people with lived experience; they are the ones who can tell us why something would be harmful."

Gabriela Zapata-Alma added that involuntary discharge from treatment is a huge issue in the US, posing a potential barrier for everyone seeking treatment. They noted that, "It's a really sad state of affairs that we have to say that people who need treatment and don't want to leave shouldn't be kicked out, especially for the very symptoms that they are there to treat."

Ms. Wilson added that it is important to remember the damaging effects of stigma: "People won't be asking for help if they will be told how bad they are. We have to make it safe for people. There is nothing worse than putting the most vulnerable moment of your life out there and being told you are horrible."

Panelists and participants alike emphasized that in order to address potential barriers and harms, service provision needs to be *guided by people with lived experience*. As **Dr. Gilbert** noted, "Without having survivors at the table, we will not be able to [address] the important questions or create services that help more than they harm." **Ms. Ramirez** added, "We don't want to send people to services that make things worse for them."

Panelists and participants reiterated that how people are treated is key to recovery, highlighting the importance of services that are empowerment-based; that treat people with dignity and respect; that foster physical, emotional, and spiritual safety; that recognize recovery as a journey; that view people accessing services as fully human; and that shape services around the person rather than vice-versa.

Panelists and participants raised a number of specific service barriers, all of which are amplified when substance use coercion is part of the picture, including:

- Restricted or limited access to domestic violence and substance use services and supports, including being prevented from accessing services by an abusive partner, lack of transportation, restricted service hours, and being screened out of services or asked to

leave after services have commenced;

- Service philosophy and practice in specific programs (e.g., placing responsibility for sobriety on the survivor, stigmatizing attitudes and practices, exposure to abusive people within substance use treatment or 12-step programs);
- Failure to qualify for or involuntary discharge from treatment or services due to externally-imposed criteria (e.g., not having identification or bringing the wrong type of identification, lack of childcare, active use, or relapse);
- Unavailability or limited availability of gender-responsive, IPV- and trauma-informed substance use services in a person's geographic area;
- Stigma associated with substance use, making people feel that they are "not fully human";
- Potential loss of custody while in treatment, even if in recovery; and
- Inadequate understanding of the intersecting issues of IPV, substance use, and substance use coercion.

SYSTEM BARRIERS

One of the most consequential system barriers that panelists and participants highlighted was that in many states and jurisdictions, survivors who use substances are at risk for having their children removed, whether or not the children's safety and wellbeing are at risk. **Ms. Pye** noted, "It is much more common for the batterer to have custody over the children rather than the mom who has the substance use issue, even if it isn't affecting the children's safety or well-being. If we cannot keep kids with the protective parent, maybe we need to redefine protection. When we focus more on the choices that the survivor is making instead of the choices that the perpetrator is making, we are harming more than we are helping."

The philosophy of a particular program and consequently the attitude of program staff toward survivors seeking services appear to make a marked difference in outcomes. One participant remarked, "Treatment facilities where people were connecting and smiling had a higher recovery level than the places where it felt like a medical facility... It's that love aspect again."

As described above, programs such Cuyahoga County's Partnering for Family Success Program are invested in preventing removals of children from families and thus reducing the need for foster care placement. This integrated domestic violence/substance use treatment program coordinates services from child welfare, substance use, mental health, and youth-serving programs. The program has saved $4 million dollars already and has reduced harms to both survivors and children.

Other system barriers to consider include the risk of involvement due to substance use with the criminal legal system, leading to the potential for incarceration and its attendant lifelong effects on

children (including revocation of custody and parental rights), housing, employment, education, and economic stability.

Theme 2: Recommendations for Reducing System Barriers, Stigma, and Harms

Similar to Theme 1, participants' recommendations to reduce stigma, barriers, and harms underscored that strategies need to be developed, implemented, and evaluated in *full partnership* with people who have lived experience. Participants again emphasized that services must embrace the needs of people "as they are," and without the expectation that they can—or even wish to—adhere to system requirements they are unable to meet or that are incongruent with their circumstances, culture, or values. Participants emphasized the importance of developing a flexible, comprehensive, and holistic array of system-level options and services.

With these guiding principles in mind, Theme 2 recommendations include the following:

- Assure that the voices of people with lived experience of IPV and substance use or substance use coercion are included as vital partners in developing and driving integrated programs. People with lived experience need to drive processes to develop clinical screening tools to ensure that they are equitable, inclusive, and do not cause harm.
- Provide stable funding for transportation, childcare, and other services that help survivors to access and maintain recovery and safety supports, particularly in rural areas and other regions not well served by public transportation.
- Expand access and promote flexible entry and retention criteria for substance use treatment services, informed by the voices of people with lived experience. Promote goals that reduce waitlist times and eliminate involuntary discharge.
- Support program philosophies that are holistic, empowerment-based, culturally relevant, trauma-informed, and survivor-defined, rather than ones that embody harmful, controlling, or punitive approaches.
- Increase awareness among program staff of the inherent dangers when abusive partners and survivors are treated together, including in mixed-gender settings. Offer gender-responsive/specific services; within those, maintain awareness to ensure that survivors are not in treatment with same-gender abusive partners.
- Provide education, training, and support for "sober homes" and other recovery supports that may be fearful of accepting people experiencing IPV due to safety concerns.
- Build partnerships with child welfare systems to ensure that all staff are trained about the dynamics of IPV, substance use, substance use coercion, and the intersections of these challenges as they affect Indigenous survivors and survivors of color, as well as those experiencing poverty, living in rural areas, with limited English proficiency, or who are disabled. The challenge of recognizing and dealing with false accusations and other

manipulative tactics of abusive partners warrants particular consideration.

- Allocate priority status to prevention-focused programming for young people aging out of foster care, centering job training, healthy relationships, parenting, financial and internet literacy, and educational advancement.
- Seek funding and other support to replicate or adapt promising integrated programs to increase survivors' safety and reduce the risk of removal of children from their custody.
- Support domestic violence and substance use program efforts to secure the services of legal advocates and attorneys with expertise in violence prevention and child welfare/custody.
- Promote education and training about domestic violence and substance use/substance use coercion for law enforcement personnel, attorneys, judges, and judicial staff.
- Promote collaborative cross-training about the dynamics of IPV and substance use/substance use coercion for all who come in contact with people who are at risk from IPV and who use substances, including those working in child welfare, law enforcement and the courts, healthcare, mental health and substance use disorder treatment, education, public benefits, and housing.
- Take careful and deliberate steps to help ensure that programs, training, and policies are trauma-informed and culturally relevant for the communities served. Particular attention should be paid to understanding the complex relationship between child removal, violence, racism, and colonization, particularly for Black, Indigenous, and people of color.
- Promote telehealth services by expanding broadband internet and smart device access for survivors exiting abusive relationships, especially in rural areas that have poor internet service availability and/or among people with limited financial resources.
- Promote interagency and cross-sector collaborations between domestic violence content experts, federal agencies, and national professional association partners to develop best practice guidelines, training, and educational materials for care providers and others who come in contact with survivors experiencing IPV, substance use, and substance use coercion.
- Utilize an accessible, culturally responsive, and trauma-informed approach, centered on the development of survivor-defined services.
- Examine all work through a social justice lens to enable service providers to recognize the root causes of violence and why some systems cause so much harm.

Theme 3: Developing and Implementing a Research Agenda on IPV, Substance Use, and Substance Use Coercion

Ms. Fairley began by asking what a research agenda on IPV, substance use, and substance use coercion should look like and how to go about shaping it. Participants raised cogent questions and

offered a range of suggestions about potential research priorities, including: increasing knowledge about substance use coercion and its impact on survivors' lives and safety; identifying, implementing, and evaluating a range of treatment and intervention models with a focus on integrated services; improving access to services; and reducing barriers and harms. Participants also encouraged the development of a research agenda around the intersections between IPV, substance use, substance use coercion, and child welfare. In all discussions, panelists and participants reiterated the importance of ensuring that research is grounded in, informed by, and driven by the voices of people with lived experience.

RESEARCH AREA 1: PREVALENCE AND IMPACT OF SUBSTANCE USE COERCION

What kinds of research should be conducted to determine the prevalence and impact of substance use coercion? Participants agreed that research is needed to further define and describe the epidemiology and impact of substance use coercion in different populations and settings. Key questions raised by the group included:

- What are the best strategies for learning more about the prevalence and impact of substance use coercion?
- What role does substance use coercion play in how survivors are impacted by systems and services?
- What are the potential impacts of emerging public policies related to substance use coercion?

Basic descriptive research about substance use coercion is limited. Qualitative data on substance use coercion can be found in a small number of published research studies, although none specifically focus on it. Only one quantitative survey has been conducted: a collaboration between the National Domestic Violence Hotline and NCDVTMH.

Participants stressed the need for prevalence and impact research in the following areas:

National Prevalence and Impact Research

Participants agreed that research should be conducted to establish the national prevalence and impact of substance use coercion through population-based surveys and to gather data about its impact in multiple populations and settings. Potential strategies include conducting new national surveys on substance use coercion as well as incorporating relevant questions into existing national surveys, such as the SAMHSA National Survey on Drug Use and Health (NSDUH), the CDC's Behavioral Risk Factor Surveillance Survey (BRFSS) and National Intimate Partner and Sexual Violence Survey (NISVS), and the National Institute of Drug Abuse (NIDA) Clinical Trials Network studies. Participants underscored the importance of epidemiologic research, noting that demonstrating the prevalence and impact of substance use coercion will be critical to developing public policy solutions regarding the opioid epidemic, access to integrated services, child welfare and criminal legal system involvement, economic self-sufficiency, and other pressing challenges.

Community and Setting-Specific Research

Participants emphasized the need for community and setting-specific research on substance use coercion. Participants pointed out how the lack of awareness about substance use coercion among service providers and systems can create barriers and harms and lead to less than optimal treatment and service provision. Documenting the ways that substance use coercion impacts people in particular service and system settings, the specific barriers it creates, and what survivors would find most helpful, will be critical to improving system responses and creating more effective services.

Validated Measures of Substance Use Coercion

Participants noted that in preparation for conducting prevalence and impact studies, validated measures of substance use coercion need to be developed. Similarly, outcomes studies on the effectiveness of substance use prevention, intervention, and treatment programs for survivors of IPV, as well as studies of domestic violence services for survivors who use substances, will require validated substance use coercion measures. To date, however, there are no published measures of substance use coercion, although NCDVTMH is currently piloting a substance use coercion scale. Validated scales of substance use coercion would allow healthcare, substance use disorder treatment, mental health, and domestic violence service providers to assess the role that substance use coercion plays in the lives of the survivors they support and the efficacy of interventions designed to address these issues. Such scales would also allow researchers to further examine the impact of substance use coercion on initiation into substance use and subsequent addiction, on the ability to participate in treatment, and on short- and long-term relapse and recovery. In addition, they would help elucidate the relationship between substance use-related coercion and a range of other critical issues, such as: child welfare and criminal legal system involvement; entrapment into human trafficking; substance use during pregnancy and consequent neonatal abstinence syndrome; maternal mortality, opioid overdose, and opioid overdose-related deaths; and outcomes of substance use disorder treatment, including MAT. Ideally, these types of studies will lead to more effective prevention and improved services for survivors dealing with both substance use and IPV.

Relationships Between Substance Use Coercion and Physical/Mental Health

Participants expressed the need for research on the potential relationship between substance use coercion, mental health, and physical health, including traumatic brain injury. Participants highlighted the role that substance use coercion can play in each of these areas; they stressed the need for research to articulate these connections in order to ensure that health and mental health providers address them.

Costs to Society

Given the impact of substance use coercion in so many domains, research that measures the costs to society of substance use coercion is also warranted. Participants suggested looking to similar studies that examine the societal costs of rape and IPV. Participants also highlighted the need to examine the impact of substance use coercion on survivors' economic self-sufficiency and housing stability.

The Impact of Emerging Public Policies and the Role of Substance Use Coercion

Kiersten Stewart, MA, Policy Director for Futures Without Violence, emphasized the need for research examining the impact of new public policies, specifically Family First and the California Department of Health Care Services' (DHCS) initiative to encourage pediatricians to screen for ACEs. Family First supports mental health and substance use treatment for families at risk for child welfare involvement. However, domestic violence services are not considered an approved Family First intervention, due in part to insufficient research demonstrating that addressing IPV in the context of mental health or substance use treatment improves outcomes for children. This in itself is an important research gap and raises the concern that people will be directed into programs that are harmful. Ms. Stewart also voiced concern about the potential impact of routine ACE screening by pediatricians, given that the list of ACEs includes exposure to IPV, parental mental health or substance use problems, and parental criminal legal system involvement. Failure to recognize the role that IPV and substance use coercion may play in children's elevated ACE scores may increase children's risk of being removed from a protective parent and leave children feeling responsible for being taken away from that parent. She concluded by endorsing efforts to gather data on how these policies impact the families they are intended to help.

RESEARCH AREA 2: STRATEGIES TO ADDRESS SUBSTANCE USE COERCION

The Development and Implementation of Evidence-Based Interventions for People Experiencing IPV, Substance Use, and Substance Use Coercion

Participants and panelists highlighted the need for evidence-based interventions that specifically address substance use coercion. There are only a handful of evidence-based treatment models focused on substance use and IPV; several others address substance use and PTSD or trauma more broadly. However, none address substance use coercion *per se*. Participants shared examples of interventions currently being developed or piloted that do address substance use coercion or could be adapted to include substance use coercion. Examples included Dr. Rothman's *Recovery in Safety* model, Dr. Gilbert's *Women Initiating New Goals of Safety (WINGS), Dr. Amanda Sedgewick's Recovering Safety: A Women's Empowerment Group for Survivors of Intimate Partner Violence with Substance Use Disorders*, and NCDVTMH's *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*.

Effective Provider Education about Substance Use Coercion

Participants stressed the need for provider education on the prevalence of substance use coercion and its effects, tools for incorporating questions about substance use coercion into routine assessments, and strategies for supporting survivors who experience substance use coercion. **Tonya McFadden, MS**, Director of Strategies for Health Equity at the American College of Obstetricians and Gynecologists, emphasized the importance of tailoring provider education to the needs of providers working in busy settings and with limited time. She also stated that training teams comprised of a clinician and person with lived experience are likely to be especially effective.

Strategies to Address and Measure Substance Use Coercion as Part of Broader Indian Health Services' Domestic Violence Prevention Initiatives

Selina Keryte MPH, Public Health Analyst, HHS, Indian Health Service, Division of Behavioral Health, National Coordinator, Domestic Violence Prevention Program, noted that funding for 83 domestic violence prevention initiatives throughout Indian country aims to build capacity to increase access to domestic violence and substance use prevention, advocacy, crisis intervention, and forensic healthcare services and to promote trauma-informed services for American Indian/Alaskan Native communities. Ms. Keryte suggested that while substance use coercion might seem to fit best under behavioral health, strategies to address and measure substance use coercion on a broader level are also warranted.

RESEARCH AREA 3: IPV, SUBSTANCE USE, SUBSTANCE USE COERCION, AND CHILD WELFARE

Two-Generation Approaches to IPV, Substance Use, and Child Welfare

Several participants highlighted innovative integrated programs that address the intersection of IPV, substance use, mental health, and child welfare as part of efforts to prevent children from being removed from their primary caregivers. **Ms. Dawson** suggested that Cuyahoga County, Ohio's pay for success model—which prioritizes domestic violence, homelessness, and substance use—might be an ideal model for piloting and replication.

Incorporating IPV and Substance Use Coercion into Research on the Intersections of Opioid Use and Child Welfare System Involvement

Theresa Armstead, PhD, Evaluation Team Lead, HHS, Centers for Disease Control and Prevention (CDC), Center for State, Tribal, Local, and Territorial Support, Division of Performance Improvement and Field Services, discussed a prevention study on the relationship between opioid and child welfare burden across the US. This study is investigating what can be learned from counties where rates of opioid use are high but child welfare involvement is low, including what they have in place that makes a difference. Dr. Armstead also highlighted work that the CDC is doing to develop indicators for social determinants of health, which funded recipients can use in their evaluations of community-level programs. She emphasized the importance of examining risk and protective factors across multiple forms of violence; she noted that substance use has not come across clearly as a risk factor and stressed the importance of expanding our thinking in this area.

RESEARCH AREA 4: EXPANDING ACCESS, INCREASING ENGAGEMENT, AND IMPROVING SERVICES AND OUTCOMES FOR SURVIVORS OF IPV WHO USE SUBSTANCES

The rich discussions of Days 1 and 2 made clear that:

1. Integrated services, while promising, are still nascent and work is needed to build out, test, and evaluate a range of approaches;
2. Even for models that have been shown to be effective, uptake has been limited, highlighting the need for research to identify challenges and support implementation; and
3. The majority of survivors who use substances are not accessing domestic violence or substance use services, highlighting the need for research to better understand barriers to access and engagement.

Participants emphasized the importance of creating a research agenda to support identification, development, implementation, evaluation, and replication of integrated services and community-level interventions for people experiencing substance use and IPV, including those that use culturally specific and Indigenous approaches. They also prioritized working in partnership with people with lived experience to identify best models and approaches for people not currently engaged in services. They noted that evaluation and outcomes research is needed to support the replication of a range of successful integrated services models and help bring them to scale. Finally, participants reiterated the importance of well-designed, survivor-driven participatory research to shape advances in services.

Peer Support Models in the Context of Substance Use and IPV

Participants emphasized the importance of peer-based models and the need for research to measure their value and effectiveness. For some presenters with lived experience, it was peers who literally saved their lives and helped them to navigate systems that consistently rejected their help-seeking efforts. Participants also recommended the incorporation of IPV and substance use coercion into Comprehensive Addiction and Recovery Act (CARA)-funded services and into their evaluation processes.

Theme 3: Recommendations for Building a Research Agenda on IPV, Substance Use, and Substance Use Coercion

Recommendations for Research on the Prevalence and Impact of Substance Use Coercion

- Support national population-based research to establish the prevalence and impact of substance use coercion as well as the inclusion of questions about substance use coercion into existing national surveys, such as the NSDUH, BRFSS, and NISVS, and into relevant NIDA Clinical Trials Network studies.
- Support both quantitative and qualitative studies on substance use coercion in a range of settings, such as domestic violence programs that serve survivors in shelter and in the community; primary care, behavioral health, pediatrics, and OB/GYN healthcare settings; child welfare and civil and criminal legal settings; and in partnership with culturally

specific, Indigenous, and LGBTQ communities, particularly those disproportionately impacted by system responses. Qualitative research should include inquiry about survivors' experiences of services, what they found most helpful, the barriers they faced, and their recommendations for improving service and system responses. Quantitative and qualitative research should also incorporate the impact of substance use coercion on people's economic wellbeing, employment, and housing stability.

- Support research on the impact of substance use coercion on health and mental health, including the medical and psychiatric complications of coerced use.
- Support research on the development of a validated substance use coercion scale to examine the prevalence and impact of substance use coercion, and as part of outcome studies related to substance use disorder treatment, domestic violence, and other services.
- Support research that measures the costs to society of substance use coercion.
- Support studies to evaluate the impact of emerging policies in which substance use coercion may play a role, including Family First interventions and public health initiatives promoting widespread screening for ACEs.

Recommendations for Research on Strategies to Address Substance Use Coercion

- Support research to develop and evaluate interventions and treatment models that specifically address substance use coercion, including those that meet the approval criteria for Family First interventions.
- Utilize Patient-Centered Outcome Research Institute (PCORI)-type models to ensure that people with lived experience guide every phase of intervention development, implementation, and evaluation.
- Support research on effective training about substance use coercion for healthcare, mental health and substance use disorder treatment, child welfare, legal, and other service providers.

Recommendations for Research on IPV, Substance Use, Substance Use Coercion, and Child Welfare

- Combine funding streams to support piloting integrated substance use and child welfare services models and determine the best strategies for prioritizing domestic violence in that context.
- Support outcomes research that can lead to the replication of successful models of addressing the intersection of substance use, IPV, and child welfare and bring them to scale.

- Support prevention research that incorporates attention to substance use and substance use coercion as root causes and/or risk factors across multiple forms of violence, including for child welfare involvement.

Recommendations for Research on Expanding Access, Increasing Engagement, and Improving Services and Outcomes for Survivors Who Use Substances

- Support exploratory research to determine how to reach people who are not currently served by substance use disorder treatment or domestic violence programs. This will help to identify why survivors who use substances are not engaging in services. It can also lead to the development of engagement strategies and service models that meet survivors "where and how they are."
- Support exploratory research to identify best integrated services models for people who use substances and experience IPV, including:
    - A continuum of collaborative, coordinated, and fully integrated residential and community-based models;
    - Culturally specific and Indigenous models;
    - Models that are housed in both domestic violence and/or substance use disorder treatment settings; and
    - Models that incorporate holistic, two-generation, gender-inclusive, culturally responsive, trauma-informed, and harm reduction approaches.
- Support exploratory research to identify promising community-level outreach interventions that integrate IPV, harm reduction, and substance use treatment services.
- Fund demonstration projects to support the development, implementation, and evaluation of integrated, holistic, survivor-driven, trauma-informed models for supporting survivors who use substances and their children, including culturally specific and Indigenous models and approaches.
- Support implementation research to identify organizational and infrastructure components necessary to deliver and evaluate integrated services.
- Require research plans to include mechanisms to ensure that people with lived experience play a central role.
- Support research to improve peer support models for IPV survivors who use substances and experience substance use coercion.
- Support research and evaluation on the adaptation and implementation of peer support models for domestic violence programs.
- Support the incorporation of information about substance use coercion and IPV into CARA-funded peer support services and evaluation processes.

DAY 2 CONCLUDING REMARKS AND NEXT STEPS

Amanda Benton, MPP, Senior Social Science Analyst, ASPE, thanked the meeting participants for a great Day 2 discussion and for building on the work of Day 1 to craft an agenda for moving forward. She emphasized the need to ensure that people with lived experience are driving the process and that services and outreach efforts meet people where they are, both emotionally and geographically. She stressed the importance of eliminating stigma, getting the message out to key audiences, and collaborating across systems. She highlighted the need for research on the prevalence and impact of substance use coercion and for identifying and supporting best practices for prevention, screening, and intervention—including integrated services and peer support approaches.

The meeting was closed with a prayer from Selina Keryte, MPH, National Domestic Violence Program Lead, Division of Behavioral Health, Indian Health Services, in Diné, her native language.

REFEREENCES

Bancroft, L. (2003). *Why Does He Do That? Inside the Minds of Angry and Controlling Men*. New York, NY: Penguin.

Beydoun, H. A., Williams, M., Beydoun, M. A., Eid, S. M., & Zonderman, A. B. (2017). Relationship of physical intimate partner violence with mental health diagnoses in the nationwide emergency department sample. Journal of Women's Health (2002), 26(2), 141–151. https://doi.org/10.1089/jwh.2016.5840

Engstrom, M., El-Bassel, N., & Gilbert, L. (2012). Childhood sexual abuse characteristics, intimate partner violence exposure, and psychological distress among women in methadone treatment. *Journal of Substance Abuse Treatment*, 43(3), 366–76. doi:10.1016/j.jsat.2012.01.005

Edmund, D.S., & Bland, P.J. (2011). *Real tools: Responding to multi-abuse trauma. A tool kit to help advocates and community partners better serve people with multiple issues*. Alaska Network on Domestic Violence & Sexual Assault. Retrieved from: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/09/RealTools_RespondingtoMultiAbuseTrauma_BlandandEdmund.pdf

Gilbert, L. (2019). How Does Law Enforcement Intersect with IPV Among Women Who Use Drugs? Presentation at the Technical Expert Meeting on *Substance Use Coercion as a Barrier to Safety, Recovery, and Economic Stability: Implications for Policy, Research, and Practice*. Washington, DC: US Department of Health and Human Services.

Girouard, M.P. & The National LGBTQIA+ Health Education Center (2018). Addressing Opioid Use Disorder Among LGBTQ populations. Boston, MA: Fenway Institute. https://www.lgbthealtheducation.org/publication/addressing-opioid-use-disorder-among-lgbtq-populations/

Johnson, M. P., & Leone, J. M. (2005). The Differential Effects of Intimate Terrorism and Situational Couple Violence: Findings from the National Violence Against Women Survey. *Journal of Family Issues*, 26(3), 322-349. https://doi.org/10.1177/0192513X04270345

Macy, R. J., & Goodbourn, M. (2012). Promoting successful collaborations between domestic violence and substance abuse treatment service sectors: A review of the literature. *Trauma, Violence, & Abuse*, 13(4), 234-251. doi: 10.1177/1524838012455874

National Center on Domestic Violence, Trauma, and Mental Health and the National Association of State Alcohol and Drug Abuse Directors (2020). Summary of key results: Addressing domestic violence and substance use disorders. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health (In press).

Phillips, H., Kaewken, O., Lyon, E. (2020a). Needs assessment on mental health and substance use challenges. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health (in press).

Phillips, H., Warshaw, C., Lyon, E., Fedock, G. (2020b). Theme report: Understanding substance use coercion in the context of intimate partner violence: Implications for policy and practice - summary of findings. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health (In press).

Phillips, H., Warshaw, C., & Kaewken, O. (2020c). Literature Review: Intimate partner violence, substance use coercion, and the need for integrated service models. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health (In press).

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, and Mental Health. Retrieved from: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/09/IPV-SAB-Final202.29.1620NO20LOGO-1.pdf

Trevillion, K., Oram, S., Feder, G., Howard, L.M. (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. *PLoS ONE*, 7(12): e51740.

Stark, E. (2007). Coercive control: *How Men Entrap Women in Personal Life*. New York, NY: Oxford University Press.

United States Department of Health and Human Services (2017). Final report: Opioid use, misuse, and overdose in women. Washington, DC: United States Department of Health and Human Services, Office on Women's Health. Retrieved from: https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf

Warshaw C., Lyon E., Bland P., Phillips, H., & Hooper M. (2014). Mental health and substance use coercion surveys: Report from the National Center on Domestic Violence, Trauma, and Mental Health and the National Domestic Violence Hotline. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health. Retrieved from: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf

Warshaw, C., & Tinnon, E. (2018). Coercion related to mental health and substance use in the context of intimate partner violence: A toolkit for screening, assessment, and brief counseling in primary care and behavioral health settings. Chicago, IL: National Center on Domestic Violence, Trauma, and Mental Health. Retrieved from: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2018/03/NCDVTMH_MHSUCoercionToolkit2018.pdf

SPEAKER BIOGRAPHIES

Amanda Benton, MPP
Amanda Benton is a Team Lead/Senior Social Science Analyst in HHS's Office of the Assistant Secretary for Planning and Evaluation. She leads work related to increasing the effectiveness of federal technical assistance and helping human services programs build and leverage social capital. She coordinates inter- and intra-agency policy work, manages research contracts, and conducts qualitative research on a wide range of topics, including economic mobility, housing instability, and human trafficking. She previously served as the Director of Policy Outreach at the National Alliance to End Homelessness. She holds an MPP from Harvard's Kennedy School of Government.

Irene Lindsay Brantley
Irene Lindsay Brantley's passion is working to empower survivors of domestic violence and substance use to make positive changes in their lives, free of addiction, poverty, and violence. As Women In Transition's (WIT) Program Director, Ms. Brantley is the force behind WIT's free and confidential domestic violence and substance use services. She created WIT's Sister Circle Peer Support group and Survivor's Network, in addition to expanding WIT's services to include therapy and multilingual programs. Ms. Brantley is a Certified Domestic Violence Counselor (CDVC) and a graduate of Philadelphia University with a BS in human resource management.

Cathy Cave
Cathy Cave has 30 years of experience as an administrator, facilitator, and consultant specializing in cultural competence and disparities elimination; trauma-informed services and supports; strength-based approaches with individuals, youth, and families; and leadership within child welfare, education, juvenile justice, disaster response, mental health, domestic and sexual violence advocacy, and corrections. She is one of New York State's early trauma champions, coordinating county collaboratives and the Mastering the Key Connection Statewide Trauma Conferences in the mid 1990's. Currently, Ms. Cave provides technical assistance on trauma, cultural competence, wellness, and peer support through the National Center on Domestic Violence, Trauma, and Mental Health; numerous programs and projects funded by Substance Abuse and Mental Health Services Administration, governmental agencies and advisory bodies, coalitions, and to human service organizations throughout the country. Formerly the Director for Cultural Competence for New York State Office of Mental Health, she uses her survivor, family, community, provider, and administrative perspectives to facilitate organizational change at local, state, and national levels.

Elizabeth Darling
Elizabeth Darling is Commissioner of the Administration on Children, Youth and Families (ACYF) at HHS's Administration for Children and Families (ACF). ACYF has two bureaus under Commissioner Darling's leadership: the Children's Bureau and the Family and Youth Services Bureau. In addition to her Senate-confirmed position in the Trump Administration, she also serves as Acting Associate

Commissioner at the Family and Youth Services Bureau. Commissioner Darling was most recently President and CEO of OneStar Foundation, which strengthens the nonprofit sector in Texas. Before that, she was CEO of the Corporation for National and Community Service and served as Deputy Secretary at the Maryland Department of Human Resources, where she oversaw childcare, child support, child welfare, domestic violence, and family assistance programs, in addition to Maryland's TANF, food stamp, and Medicaid programs. Commissioner Darling's current position at ACYF is her second appointment at HHS. During the Bush Administration she was the founding director of HHS's Center for Faith-Based and Community Initiatives. Prior to that, she served as Vice Chairwoman of the Texas Department of Human Services, overseeing welfare-to-work programs. Commissioner Darling has a BS in education from Baylor University and is an adoptive mother with three children and two grandchildren.

Shawndell Dawson

Shawndell N. Dawson is the Director of the Family Violence Prevention and Services Act (FVPSA) Program in the Family and Youth Services Bureau at HHS's Administration for Children and Families. FVPSA addresses domestic violence as a public health issue and partners with the continuum of social service agencies and domestic violence service providers that families turn to for help. The FVPSA Program supports a network of domestic violence programs across the country including over 1,600 local, community-based programs; state domestic violence coalitions; the National Domestic Violence Hotline; StrongHearts Native Helpline; national training and technical assistance providers; culturally-specific resource centers; and specialized programs for abused parents and children experiencing violence and trauma. Director Dawson has over 20 years of experience working on local, state, and national levels, and began her federal career in 2010 as Senior Program Specialist for the FVPSA Program managing training, technical assistance, research, and inter-agency collaborations with over 15 federal agencies addressing systemic responses to domestic violence. Prior to joining the civil service, Director Dawson worked for state domestic violence coalitions and national organizations, including the DC Coalition Against Domestic Violence, the Ohio Domestic Violence Network, and the National Network to End Domestic Violence. Director Dawson's policy expertise includes serving as the Family and Youth Services Bureau's (FYSB) Policy Manager, where she worked in partnership with all three of FYSB's programs to assess the implementation of the Runaway and Homeless Youth Act, FVPSA, and Title V of the Social Security Act.

Laura Erickson, MPP

Laura Erickson is a Social Science Analyst in the Office of the Assistant Secretary for Planning and Evaluation at HHS. She conducts qualitative research and policy analysis on domestic violence and human trafficking and also contributes to cross-cutting work on social capital and economic mobility. Ms. Erickson's previous educational and work experience focused on criminal justice and early childhood policy. She holds an MPP from George Washington University.

Kenya Fairley, MSEd

Kenya Fairley is a Supervisory Program Specialist in the Family Violence Prevention and Services Act (FVPSA) Program in the Family and Youth Services Bureau at HHS's Administration for Children and Families. She brings over 20 years of experience from across the domestic violence field. Ms.

Fairley has worked in dual domestic violence and sexual assault programs and at statewide agencies focused on policy and practice related to domestic violence and child maltreatment. Ms. Fairley has served in leadership roles at the National Resource Center on Domestic Violence overseeing national technical assistance, training, and resource development on a multitude of intersecting issues. She was previously Executive Director at the Administration for Children's Services in New York City government, implementing a workforce institute initiative to offer advanced learning programs and supervisory coaching to over 6,200 child welfare social workers. Ms. Fairley's passion for addressing domestic violence is rooted in providing comprehensive, accessible safety nets and protections for survivors and their children and her belief that the best way to keep children safe is to ensure their parents are safe. She is also a birth doula focused on trauma-informed birth support for survivors of domestic/sexual violence.

Neeraj Gandotra, MD

Dr. Gandotra serves as the Chief Medical Officer for SAMHSA. Previously, Dr. Gandotra served as the Chief Medical Officer for the fourth largest nationwide addiction treatment network, where he developed national strategies specifically aimed at reducing risk and improving outcomes. He is familiar with the development and utilization of medical services budgets, nuances of regulations, and codes across various states. As Medical Director of Addiction Treatment Services at Johns Hopkins, he directed patient care through implementing department initiatives and medical center resources. Dr. Gandotra was tasked with both administrative and supervisory roles for all providers and clinics within Addiction Treatment Services. Dr. Gandotra has also worked as a Medical Director for federally qualified health centers where it was necessary to develop policies mindful of specific catchment area needs.

Janette Garcia

Janette Garcia has worked at Haven Women's Center of Stanislaus for 22 years. In that time, she managed domestic violence services at Behavioral Health Services (Welfare to Work), was on a collaborative team in child welfare for five years, and facilitated Batterer's Re-Education (a 52-week court-ordered offender treatment). Ms. Garcia was the Haven Program Manager at the Stanislaus Family Justice Center and facilitates trauma support groups in substance use treatment centers. She is currently the Training Manager overseeing the 72-hour, state-certified Sexual Assault, Domestic Violence & Human Trafficking training. She has provided crisis intervention, case management, safety planning, court accompaniment, and individual counseling for clients throughout her time at Haven. Ms. Garcia has 27 years clean and sober.

Louisa Gilbert, PhD

Dr. Gilbert is an Associate Professor at Columbia University School of Social Work and has served as Co-Director of the Social Intervention Group (SIG) since 1999. For the past 25 years her research has focused on developing, implementing, and testing multi-level interventions that address the syndemic mechanisms linking substance misuse, gender-based violence (GBV), trauma, and HIV/AIDS in the US, Central Asia, and India. This research has advanced evidence-based interventions to prevent GBV and HIV among women who use drugs (see projectwings.org). She has co-authored over 150 peer-reviewed articles from this research.

Kelly Kinnison, PhD

Dr. Kinnison is Director of the Division of Family and Community Policy in the Office of the Assistant Secretary for Planning and Evaluation. She oversees the development of policy research and analysis on employment and self-sufficiency, domestic violence, housing and homelessness, human trafficking, incarceration and reentry, child support enforcement, local community strategies to address poverty, and related cross-cutting human services issues. Dr. Kinnison came to HHS from the Department of Agriculture's Food and Nutrition Service, where she served as Branch Chief of a team conducting research and analysis on the Supplemental Nutrition Assistance Program. Prior to working for the federal government, Dr. Kinnison served as an evaluation consultant for community organizations working on violence prevention and mentoring, including Kansas City's Domestic Violence Network and the Illinois Center for Violence Prevention. She has published work on women's alcohol use, Sexual Assault Nurse Examiner programs, and intersections of the legal system and intimate partner violence. Dr. Kinnison holds a PhD in community psychology from the University of Illinois at Chicago.

Christina Love

Christina Love is an Alaska Native from Egegik village who was raised in Chitina, Alaska. Ms. Love is consultant, recovery coach, and civil and human rights activist. She has dedicated the last 7 years to systems change for targeted and marginalized populations in Alaska. She is a formerly incarcerated person in long-term recovery who currently works as a Specialist for the Alaska Network on Domestic Violence and Sexual Assault (ANDVSA), the state's coalition of domestic and sexual violence programs. Ms. Love's role focuses on intersectionality with an emphasis on trauma and substance use. At ANDVSA, she works with programs, agencies, and communities state- and nation-wide to address the continuum of care for support services through strategic initiatives, substance use screening, training and technical assistance, community-based organization, integrated services, curriculum development, evaluation, assessment, and organizational and community healing.

Eleanor Lyon, PhD

Dr. Lyon retired as Director of the Institute for Violence Prevention and Reduction at University of Connecticut School of Social Work in 2011. During a career of over 35 years, she directed a domestic violence shelter and conducted national, state, and local research. She remains active as a consultant with the National Center on Domestic Violence, Trauma, and Mental Health and Futures Without Violence. She continues to collaborate with advocates and survivors from diverse communities to develop research and evaluation tools for coercion scales, needs assessments, and trauma-informed practice and outcomes for survivors. Dr. Lyon co-authored Domestic Violence Advocacy, among other publications.

Gwendolyn Packard

Gwendolyn Packard (Ihanktonwan Dakota), Training and Technical Assistance Specialist, National Indigenous Women's Resource Center, has worked for many years in Indian country, both at the national and tribal levels. She has served as editor for six national Indian publications. In 1990 she was instrumental in founding the National Organization on Fetal Alcohol Syndrome (NOFAS). She served as Executive Director for Morning Star House, an advocacy program that works with off reservation Indian women and children who are victims of domestic and sexual violence. She also served as

Executive Director of the New Mexico Suicide Prevention Coalition and is Founder and Co-Chair of Rain Cloud, the off reservation behavioral health collaborative in Albuquerque, New Mexico. Ms. Packard is a survivor of domestic violence, a writer, a grass roots organizer, and a community activist. She has made a commitment to social change in working to address social and economic justice issues that affect the health and well-being of Indian people as documented in her work experience.

Heather Phillips, MA

Heather Phillips serves as Research Director at the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH). At NCDVTMH, she has contributed to research on mental health and substance use coercion, co-developed measures of trauma-informed domestic violence practice, conducted national needs assessments, and overseen work identifying promising practices and model domestic violence programs. Prior to joining NCDVTMH in 2012, Ms. Phillips managed research on the relationship between stress and substance use at the University of Chicago and peer- and recovery-focused mental health policy research at the University of Illinois at Chicago. Ms. Phillips has also served as a rape crisis advocate.

Angie Pye

Angie Pye has years of experience working in the domestic violence field, with particular experience in community coordination in rural areas. Ms. Pye began her employment with Beacon Center (also known as the Domestic Abuse Council of Volusia) as the CEO in September 2016. She was Executive Director of the Lee Conlee House in Putnam County for four years, after working for two years with the Florida Coalition Against Domestic Violence (FCADV) as a Domestic Violence and Child Advocacy Specialist. In her role as Executive Director, Ms. Pye started a program to increase access to services for survivors of domestic violence also dealing with substance misuse. The program goals were to ensure safety of survivors in a shelter setting, while also providing them with needed supports to address substance misuse. Ms. Pye gained much of her experience as a Program Director with Another Way, Inc. from 1997-2009. There she worked directly with battered women and their children, supervising two shelters and outreach offices in seven rural counties. During this time, she also worked with local Child Protective Services and Community Based Care agencies to bring survivor-focused services to families. As a trainer, she has provided numerous trainings on a state level to varied service provider agencies working with battered women and their children on dynamics, communication, and community coordination.

Emily Rothman, ScD

Dr. Rothman is a Professor at the Boston University School of Public Health with secondary appointments in the Departments of Pediatrics and Emergency Medicine. She is also a visiting scientist at the Harvard Injury Control Research Center (HICRC) and Ortner Center on Violence and Abuse in Relationships at the University of Pennsylvania. Dr. Rothman has authored more than 100 publications that span the areas of intimate partner violence, sexual assault, human trafficking, and pornography. Her focus is on marginalized populations and health inequity. She has been the PI of research grants from the National Institutes of Health, National Institute of Justice, Department of Defense, the Robert Wood Johnson Foundation, and others.

Alison Malinowski Sunday, MSA

Alison Malinowski Sunday has served as Executive Director at Lafayette House in Joplin, Missouri since 1995. Lafayette House provides comprehensive, gender-specific services for women and their dependent children who are affected by interpersonal violence, sexual assault, and/or substance use disorders. The organization assists over 1,200 people from Southwest Missouri each year. Ms. Sunday is a founding member of the Missouri Coalition Against Domestic and Sexual Violence. She served on the Missouri Department of Health's Women's Health Council, Missouri's Trauma Services Advisory Committee, and Missouri's Advisory Council for Women's Substance Use Treatment Services.

Carole Warshaw, MD

Dr. Warshaw is the Director of the National Center on Domestic Violence, Trauma, and Mental Health. She has been at the forefront of developing collaborative models and building system capacity to address the mental health, substance use, and advocacy concerns of survivors of domestic violence and other trauma, and to create accessible, culturally responsive, domestic violence- and trauma-informed services and organizations. She has written and spoken extensively on these topics both nationally and internationally and has served as an advisor to numerous health, mental health, and advocacy organizations and federal agencies. Dr. Warshaw has maintained a private practice in psychiatry since 1989 and is an adjunct faculty member in the Department of Psychiatry at the University of Illinois.

Sara Wilson

Sara Wilson is 26 years old and lives in a small town in the Upper Peninsula of Michigan. She is a single mom to a beautiful girl and aspiring to be an emergency medical technician. She is a survivor of human trafficking that started a cycle of a heavy drug addiction. Through perseverance and faith, Ms. Wilson can say that she is four and a half years in recovery. She is determined to use her voice in order to make a difference through her experience.

Gabriela Zapata-Alma, LCSW, CADC

Gabriela Zapata-Alma is the Director of Policy and Practice for Domestic Violence and Substance Use at the National Center for Domestic Violence, Trauma, and Mental Health, as well as faculty at The University of Chicago, where they coordinate the Advanced Alcohol and Other Drug Counselor certification program. They bring over 15 years of experience supporting survivors of domestic violence and other trauma, as well as people impacted by housing instability, HIV/AIDS, substance use disorders, and mental health conditions; providing direct services, training, advocacy, and consultation; and leading programs using trauma-informed approaches, motivational interviewing, harm reduction, gender-responsive care, Housing First, and third-wave behavioral interventions. Gabriela Zapata-Alma has been recognized with numerous awards, including Health & Medicine Policy Research Group's 2018 Health Award and the 2017 Rising Star Award from the Illinois chapter of the National Association for Addiction Professionals (NAADAC). They provide training and technical assistance related to serving marginalized communities impacted by trauma and other social determinants of health nationally and internationally.

PARTICIPANT LIST

Stephanie Alexander, MS
Department of Health and Human Services
Office on Women's Health
Health Scientist
(202) 401-9546
sia92001@yahoo.com

Theresa Armstead, PhD
Department of Health and Human Services
Centers for Disease Control and Prevention,
Evaluation Team Lead, Program Development,
Evaluation, and Training Branch
CDC |CSTLTS |Division of Performance Improvement
and Field Services
(770) 488-3904
tarmstead@cdc.gov

Erin Bagalman, MSW
Department of Health and Human Services
Office of the Assistant Secretary for Planning and
Evaluation
Director, Division of Behavioral Health & Intellectual
Disability Policy
(202) 205-6741
erin.bagalman@hhs.gov

Amanda Benton, MPP
Department of Health and Human Services
Office of the Assistant Secretary for Planning and
Evaluation
Senior Social Science Analyst
(202) 690-7290
Amanda.Benton@hhs.gov

Jasmin Brandow, MA
HumanKind Workshop
Consultant
(518) 229-8651
jasbrand@gmail.com

Irene L. Brantley
Women In Transition
Program Director
(215) 564-5301 ext 130
ilbrantley@helpwomen.org

Michelle Brickley
Department of Justice
Office on Violence Against Women
Associate Director
(202) 514-3590
michelle.brickley@usdoj.gov

Jennifer Burnszynski, MA
Department of Health and Human Services
Office of the Assistant Secretary for Planning and
Evaluation
Associate Deputy Assistant Secretary of Human
Services Policy
(202) 690-7409
Jennifer.Burnszynski@hhs.gov

Katherine Chon, MPA
Department of Health and Human Services
Administration for Children and Families
Director Office on Trafficking in Persons
(202) 401-9372
Katherine.Chon@acf.hhs.gov

Lisa Coffman
Department of Housing and Urban Development
Office of Special Needs Assistance Programs
Senior Program Specialist
(202) 402-5908
Lisa.R.Coffman@hud.gov

Heather D'Onofrio, MPH
National Association of State Alcohol and Drug
Abuse Directors
Research Analyst
(202) 292-4874
Hdonofrio@nasadad.org

Shawndell Dawson
Department of Health and Human Services
Administration for Children and Families
Family and Youth Services Bureau
Director, Family Violence Prevention and Services
Program
(202) 205-1476
shawndell.dawson@acf.hhs.gov

Laura Erickson, MPP
Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Social Science Analyst
(202) 260-6521
laura.erickson@hhs.gov

Kenya Fairley, MSEd
Department of Health and Human Services
Administration for Children and Families
Family and Youth Services Bureau
Family Violence Supervisory Program Specialist
(202) 690-6898
kenya.fairley@acf.hhs.gov

Julie Fliss, MSW
Department of Health and Human Services
Administration for Children and Families
Children's Bureau
Child Welfare Program Specialist
(202) 205-8879
julie.fliss@acf.hhs.gov

Neeraj Gandotra, MD
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Chief Medical Officer
(240) 276-2893
Neeraj.Gandotra@samhsa.hhs.gov

Janette Garcia
Haven Women's Center of Stanislaus
Training Manager
(209) 312-2636
jgarcia@havenwcs.org

Robin Ghertner, MPP
Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Director, Division of Data and Technical Analysis
(202) 795-7582
robin.ghertner@hhs.gov

Louisa Gilbert, PhD
Columbia University School of Social Work
Associate Professor
(917) 880-7328
lg123@columbia.edu

Charlotte Harris, MHR
Department of Labor
Office of Workforce Investment
Workforce Analyst
(202) 693-2863
harris.charlotte@dol.gov

Stephen Hayes
Department of Health and Human Services
Health Resources and Services Administration
Office of Women's Health
Public Health Analyst
(301) 443-2854
shayes@hrsa.gov

Keisher Highsmith, DPH
Department of Health and Human Services
National Institute on Drug Abuse
Health Scientist
Administrator
(301) 402-1984
keisher.highsmith@nih.gov

Carolyn Hightower, MPA
Department of Health and Human Services
Administration for Children And Families
Deputy Director, Office on Trafficking in Persons
(202) 205-5782
Carolyn.Hightower@acf.hhs.gov

Cheri Hoffman, PhD
Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Director, Division of Children and Youth Policy
(202) 260-2865
Cheri.Hoffman@hhs.gov

Selina Keryte, MPH
Department of Health and Human Services
Indian Health Service
Division of Behavioral Health
National Coordinator, Domestic Violence Prevention Program,
Public Health Analyst
(301) 443-7064
Selina.Keryte@ihs.gov

Kelly Kinnison, PhD
Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Director, Division of Family and Community Policy
(202) 730-3904
Kelly.Kinnison@hhs.gov

Elizabeth E. Krans, MD
University of Pittsburgh
School of Medicine
Associate Professor
(412) 641-3532
kransee@upmc.edu

Christina Love
Alaska Network on Domestic Violence and Sexual Assault Specialist
(907) 500-8914
clove@andvsa.org

Ginger Baran Lyons
Department of Justice
Office on Violence Against Women
Senior Program Analyst
(202) 305-2093
virginia.baran@usdoj.gov

Tonya McFadden, MS
American College of Obstetricians and Gynecologists
Director, Strategies for Health Equity
(202) 863-1635
tmcfadden@acog.org

Sidhartha Nilakanta, MBA
Department of Housing and Urban Development
Office of Special Needs Assistance Programs
Special Needs Assistance Specialist
(202) 402-3297
Sidhartha.Nilakanta@hud.gov

Heidi Notario, MA
National Resource Center on Domestic Violence
Vice President, Strategic Partnerships & Systems Change
(800) 537-2238 ext 111
hnotario@nrcdv.org

Rachel Orsinger, JD
Department of Health and Human Services
Administration for Children and Families
Family and Youth Services Bureau
Senior Family Violence Program Specialist
(202) 205-9814
rachel.orsinger@acf.hhs.gov

Gwendolyn Packard
National Indigenous Women's Resource Center
Training and Technical Assistance Specialist
(505) 259-3693
gpackard@niwrc.org

Elizabeth Pfenning
Department of Health and Human Services
Administration for Children and Families
Office on Trafficking in Persons
Program Specialist
(202) 401-4664
elizabeth.pfenning@acf.hhs.gov

Brian Pinero, MSSW
Department of Health and Human Services
Administration for Children and Families
Family and Youth Services Bureau
Family Violence Program Specialist
(202) 401-5524
brian.pinero@acf.hhs.gov

Angie Pye
Beacon Center
Chief Executive Officer
(386) 333-6839
apye@mybeaconcenter.com

Rachel Ramirez, LISW-S
Ohio Domestic Violence Network
Training Director
(614) 781-9651
rachelr@odvn.org

Allison Randall
National Network to
End Domestic Violence
Vice President of Policy and Emerging Issues
(202) 532-5566
arandall@nnedv.org

Emily Rothman, ScD
Boston University School of Public Health
Professor
(617) 358-1470
erothman@bu.edu

Farzana Safiullah, MPA
National Resource Center on Domestic Violence
Chief Executive Officer
(800) 537-2238 ext 102
fsafiullah@nrcdv.org

Amanda Sedgewick, DO
McLean Hospital/Harvard Medical School,
AAAP
Psychiatrist
(207) 747-9581
asedgewick1@partners.org

Veronica Smith, MSW
Department of Justice
Office on Violence Against Women
Grant Manager
(202) 514-0393
veronica.smith@usdoj.gov

Alison Malinowski Sunday, MSA
Lafayette House
Executive Director
(417) 782-1772
alisonmsunday@lafayettehouse.org

Laurie Thompsen, MSW
West Virginia Coalition Against Domestic
Violence
Health & Behavioral Health Coordinator
(304) 965-3552
lthompsen@wvcadv.org

Arlene Vassell
National Resource Center on Domestic Violence
Vice President of Programs, Prevention, and Social
Change
(800) 537-2238 ext 201
avassell@nrcdv.org

Sis Wenger
National Association for Children of Addiction
President, Chief Executive Officer
(301) 468-0985
swenger@nacoa.org

Kristina West, MS
Department of Health and Human Services
Office of the Assistant Secretary for Planning and
Evaluation
Policy Analyst
(202) 774-4220
kristina.west@hhs.gov

Melanie Whitter
National Association of State Alcohol and Drug Abuse
Directors
Director of Research and Program Applications
(202) 292-4873
mwhitter@nasadad.org

Sara Wilson
Survivor
Lived Experience Panelist
(906) 239-6412
Saranwilson906@yahoo.com

NCDVTMH STAFF AND CORE CONSULTANTS

Karla Alegria, MS
National Center on Domestic Violence, Trauma, and Mental Health
Project Manager
(312) 726-7020 ext. 2012
kalegria@ncdvtmh.org

Cathy Cave
National Center on Domestic Violence, Trauma, and Mental Health
Senior Training Consultant
(518) 461-6242
ccave@ncdvtmh.org

Eleanor Lyon, PhD
National Center on Domestic Violence, Trauma, and Mental Health
Senior Research Consultant
(208) 292-4681
elyon1313@gmail.com

Heather Phillips, MA
National Center on Domestic Violence, Trauma, and Mental Health
Research Director
(312) 726-7020 ext. 2022
hphillips@ncdvtmh.org

Sally Schaeffer, MPA
National Center on Domestic Violence, Trauma, and Mental Health
Consultant
(571) 277-6423
sally@uncorkedadvocates.com

Carole Warshaw, MD
National Center on Domestic Violence, Trauma, and Mental Health
Director
(312) 726-7020 ext. 2014
cwarshaw@ncdvtmh.org

Gabriela Zapata-Alma, LCSW CADC
National Center on Domestic Violence, Trauma, and Mental Health
Director of Policy and Practice for Domestic Violence and Substance Use
(312) 726-7020 ext. 2011
gzapata@ncdvtmh.org