

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*

Carole Warshaw, MD and Erin Tinnon, MSW, LSW

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Introduction

There is now a large body of research demonstrating that experiencing abuse by an intimate partner is associated with a wide range of health and mental health consequences. Some are the direct results of physical and sexual violence; others are related to the traumatic psychophysiological effects of ongoing abuse. Both clinical and population-based studies indicate that victimization by an intimate partner places people at significantly higher risk for depression, anxiety, posttraumatic stress disorder, somatization, medical problems, substance use, and suicide attempts, whether or not they have suffered physical injury. In addition, there are high rates of IPV among people accessing services in health and behavioral health settings (Phillips, 2014; Dillon, Hussain, Loxton, & Rahman; Nathanson, Shorey, Tirone, & Rhatigan, 2012; Trevillion, Oram, Feder, & Howard, 2012; Howard, Oram, Galley, Trevillion, & Feder, 2013; Riviera et al., 2015; Warshaw, Brasher, and Gill, 2009).

Less well researched, however, are the ways that people who abuse their partners engage in coercive tactics related to their partner's mental health or substance use as part of a broader pattern of abuse and control – tactics we refer to as mental health coercion and substance use coercion. These tactics include an abusive partner's efforts to intentionally undermine their partner's sanity or sobriety, interfere with their treatment, control their medication, sabotage their recovery, and discredit them with friends, family, helping professionals, and the courts. Pervasive societal stigma associated with substance use and mental health conditions contributes to the effectiveness of these tactics (Warshaw, Lyon, Bland, Phillips, and Hooper, 2014).

Intimate partner violence (IPV) can be understood as intentional, ongoing, systematic abuse intended to exercise power and control over an intimate partner. This can take the form of physical, sexual, emotional, and/or economic abuse, and can also include emotional manipulation of children, threats related to deportation or child custody, and outing a partner's gender identity or sexual orientation, in addition to coercion around reproduction, substance use, and mental health. When we say partner, we mean someone with whom a person has an intimate relationship including current or former spouses, sexual partners, someone a person is dating, or someone with whom a person has a significant emotional connection. It is important for clinicians to be aware of the ways that abusers use coercive tactics to control their partners and of the impact these tactics have not only on survivors' health, mental health, and well-being but also on their ability to engage in treatment and achieve their treatment and recovery goals. While we use the term intimate partner violence throughout this document, community-based programs often refer to themselves as domestic violence and/or sexual assault agencies. In

addition, we use the terms “patient” and “client” interchangeably throughout this document knowing that there are a variety of terms used to describe people who access our services.

KEY DEFINITIONS

COERCION

Use of force or manipulation to control an intimate partner’s thoughts, actions, and behaviors through violence, intimidation, threats, degradation, isolation, and/or surveillance. In the context of intimate partner violence, coercion can involve financial, psychological, physical, sexual, reproductive, and other kinds of abuse to undermine and control an intimate partner. There are two specific forms of coercion that we discuss in this toolkit – mental health coercion and substance use coercion.

MENTAL HEALTH COERCION

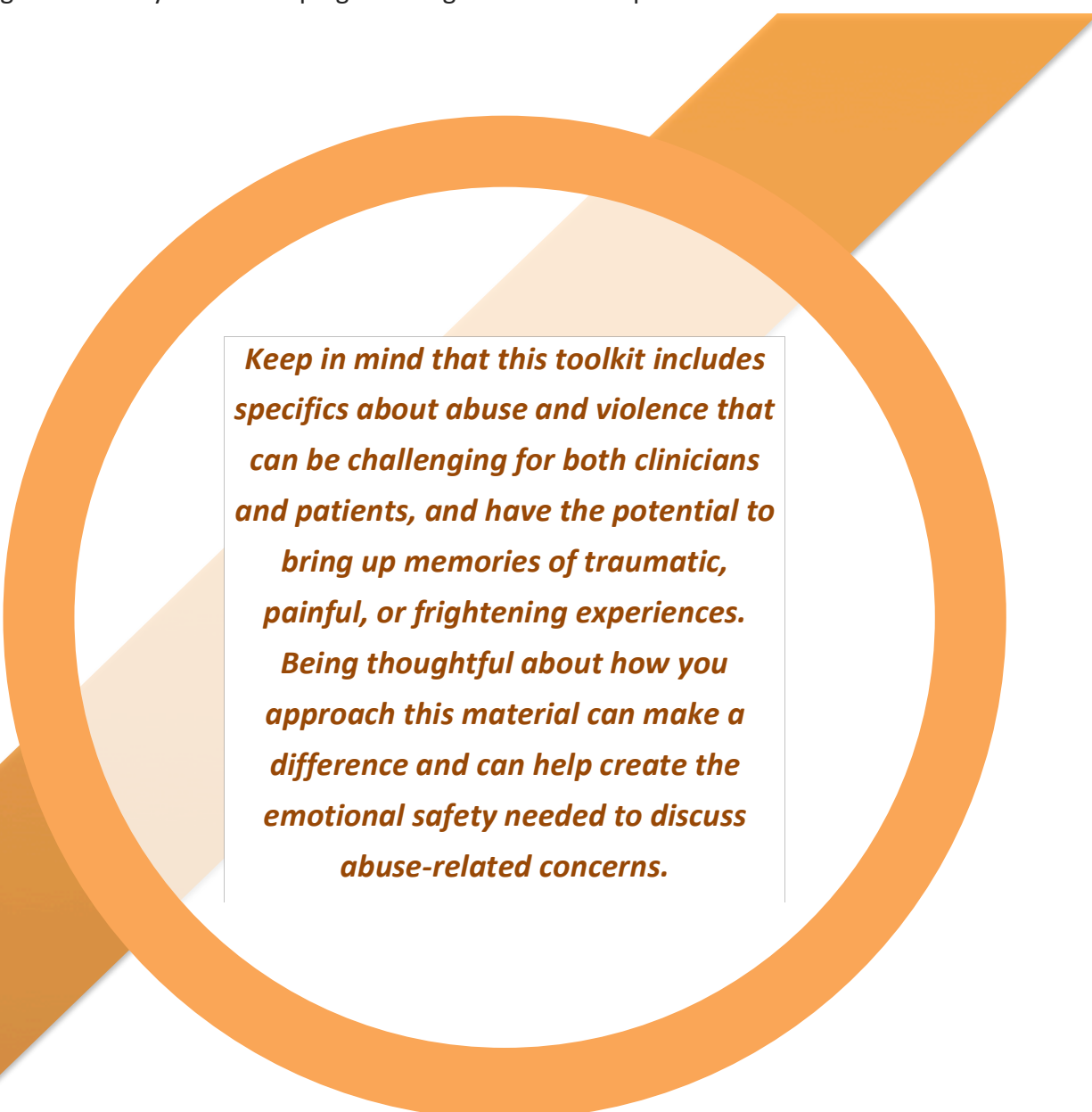
Abusive tactics targeted towards a partner’s mental health as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation and can include deliberately attempting to undermine a survivor’s sanity, preventing a survivor from accessing treatment, controlling a survivor’s medication, using a survivor’s mental health to discredit them with sources of protection and support, leveraging a survivor’s mental health to manipulate police or influence child custody decisions, and/or engaging mental health stigma to make a survivor think no one will believe them, among many other tactics.

SUBSTANCE USE COERCION

Abusive tactics targeted towards a partner’s substance use as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation and can include forcing a survivor to use substances or to use more than they want, using a survivor’s substance use to undermine and discredit them with sources of protection and support, leveraging a survivor’s substance use to manipulate police or influence child custody decisions, deliberately sabotaging a survivor’s recovery efforts or access to treatment, and/or engaging substance use stigma to make a survivor think that no one will believe them, forcing a partner into withdrawal, among many other tactics.

This toolkit provides trauma-informed guidance on integrating questions about mental health and substance use coercion into routine mental health and substance use histories and into in-depth IPV assessments in primary care and behavioral health settings. This toolkit is intended to be used in conjunction with comprehensive guidance on trauma-informed approaches to screening, assessment, and brief intervention for IPV in healthcare, mental health, and substance abuse treatment settings (For additional guidance, see Appendix B).

Given the many forms of IPV and range of experiences people may have, being able to think creatively with survivors about their particular circumstances, priorities, and needs is critical to strategizing about safety and developing meaningful treatment options.



Keep in mind that this toolkit includes specifics about abuse and violence that can be challenging for both clinicians and patients, and have the potential to bring up memories of traumatic, painful, or frightening experiences. Being thoughtful about how you approach this material can make a difference and can help create the emotional safety needed to discuss abuse-related concerns.

BACKGROUND: PREVALENCE OF MENTAL HEALTH AND SUBSTANCE USE COERCION

Background: Prevalence of Mental Health and Substance Use Coercion

A pair of surveys conducted by the National Domestic Violence Hotline (NDVH), in consultation with the National Center on Domestic Violence, Trauma & Mental Health, found disturbingly high rates of abuse specifically targeting survivors' mental health and/or substance use. While survivors have reported these tactics for decades, this survey provided the first quantitative data on the issue. These data confirmed that people who abuse their partners intentionally do or say things to undermine their partner's mental health, coerce their partners into using substances, control their partner's access to treatment, and jeopardize their partner's credibility with potential sources of protection and support.

The **Mental Health Coercion Survey** was administered over a period of six weeks to NDVH callers who identified as having experienced IPV and who were not in immediate crisis. 2,741 people agreed to participate in the survey. Results were as follows:

- ◆ **85.6%** said that a partner or ex-partner had called them “crazy” or accused them of being “crazy.”
- ◆ **73.8%** said that a partner or ex-partner had deliberately done things to make them feel like they were going crazy or losing their mind.
- ◆ **53.5%** said that in the last few years, they had gone to see someone like a counselor, social worker, therapist, or doctor to get help with feeling upset or depressed, and of those, **49.8%** said that a partner or ex-partner tried to prevent or discourage them from getting that help or taking medication they were prescribed for those feelings.
- ◆ **50.2%** said that a partner or ex-partner threatened to report to authorities that they are “crazy” to keep them from getting something they wanted or needed (e.g., custody of children, medication, protective order).

The **Substance Use Coercion Survey** was also administered over a period of six weeks to NDVH callers who identified as having experienced IPV and who were not in immediate crisis. 3,248 people agreed to participate in the survey. Results were as follows:

- ◆ **26.0%** reported using alcohol or other drugs as a way to reduce the pain of their partner or ex-partner's abuse.
- ◆ **27.0%** said that a partner or ex-partner had pressured or forced them to use alcohol or other drugs, or made them use more than they wanted.
- ◆ **15.2%** reported that, in the last few years, they tried to get help for their use of alcohol or other drugs; of those, **60.1%** said that a partner or ex-partner had tried to prevent or discourage them from getting that help.
- ◆ **37.5%** said that a partner or ex-partner had threatened to report their alcohol or other drug use to someone in authority to keep them from getting something they wanted or needed (e.g., custody of children, a job, benefits, or a protective order).
- ◆ **24.4%** reported being afraid to call the police for help because their partner said they wouldn't believe them because they were using, or that they would be arrested for being under the influence of alcohol or other drugs.

Overall, results showed that experiences of mental health and substance use coercion were common among hotline callers: **89% had experienced at least one type of mental health coercion and 43% had experienced at least one type of substance use coercion.** Most of the callers who reported any type reported more than one. For example, many callers who reported that their abusive partner called them “crazy” and did things deliberately to make them feel “crazy,” also reported that their partners threatened to undermine their credibility with authorities and discouraged or prevented them from getting help. Similarly, many callers who reported that their abusive partners used force or pressure to get them to use substances also reported that their partners threatened to undermine them with authorities by disclosing their substance use. More specifically, **over 50% of those who sought help for their mental health and over 60% of those who sought help for substance use, said their partners tried to interfere with treatment.** Further analyses demonstrated that the more types of coercion survivors experienced, the more likely they were to seek help.

**ADDRESSING
MENTAL HEALTH
AND
SUBSTANCE USE
COERCION
IN CLINICAL PRACTICE:
WHAT DOES
THIS MEAN
FOR CLINICIANS?**

Addressing Mental Health and Substance Use Coercion in Clinical Practice: What does this mean for clinicians?

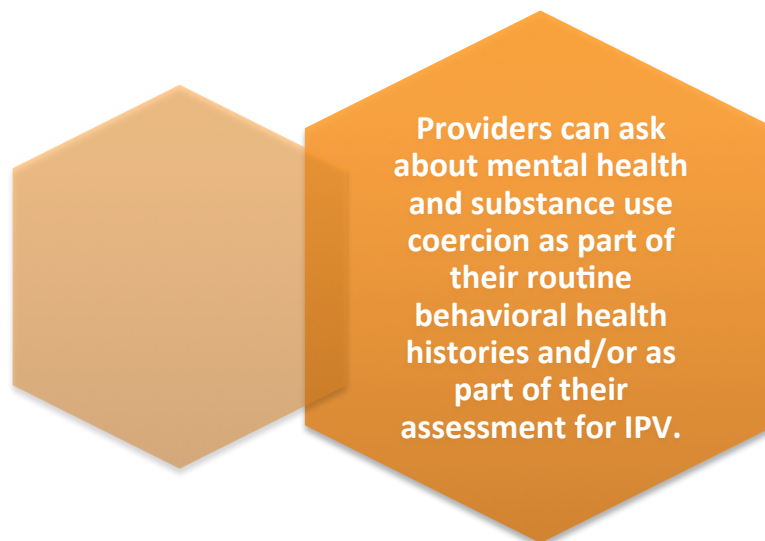
Providing appropriate treatment for any mental health or substance use condition requires an understanding of the factors that led to its development and the circumstances that impact treatment and recovery. In the context of intimate partner violence (IPV), this means recognizing that in addition to experiencing the traumatic effects of abuse, many survivors experience coercive tactics specifically related to their mental health or use of substances. Both of these, in turn, can impact survivors' mental health and well-being, their access to safety, and their ability to access or participate in treatment. Thus, routine assessment for mental health and substance use coercion and IPV-related trauma, along with specifically tailored counseling, referrals, and treatment are critical to the provision of good clinical care.

If your practice is not already set up to respond to IPV, there are a number of steps you can take to prepare. These include ensuring that everyone working in your practice receives training on understanding and responding to IPV, that policies and procedures are in place regarding safety and confidentiality, that written information and resources are available for patients, and that warm referral mechanisms have been established with IPV experts and programs in your community. Depending on your practice setting, think through what level of counseling you are able to provide and to whom you will refer for more in-depth assessment and support. For example, have you reached out to your local DV program(s) and/or hotline(s) to learn about their services and to establish clear referral processes and consultation relationships, including policies regarding information sharing and informed consent? Alternatively, is there

someone onsite with expertise on trauma and IPV who can take on this role (e.g., a designated social worker or an in-house advocate)? If you are working in a more intensive treatment setting, consider what additional kinds of IPV services you might be able to offer onsite, ideally in partnership with a domestic violence agency (e.g., offering co-facilitated IPV groups, onsite IPV advocacy and counseling programs, IPV counseling via telemedicine). For a summary of key elements for responding to IPV in clinical practice, see Appendix A.

Routine Inquiry and Assessment

Providers can ask about mental health and substance use coercion as part of their routine behavioral health histories and/or as part of their assessment for IPV. Including questions about the connection between a person's relationship with their partner and their mental health and/or use of substances creates an opportunity for someone who is experiencing IPV to think about how these issues might be connected for them. It also allows clinicians to provide more appropriately tailored counseling, treatment, and referrals. Given that some forms of treatment might not be accessible for a person who is in an abusive relationship – compounded by additional factors such as lack of child care, living in a rural area, or the need to obtain consent from a parent or guardian – having a range of options available is particularly important.





ASKING ABOUT MENTAL HEALTH COERCION

IPV Assessment | Mental Health History

Asking About Mental Health Coercion

There are a number of ways that questions about mental health coercion can be woven into an IPV assessment or mental health history. Often, providers engage family members in the gathering of collateral information to better understand what is happening for their client. Many people who abuse their partners take these opportunities to deny or minimize the abuse. They may also lie outright about their partner's symptoms, behavior, and stability. It is important to ensure that you talk with clients privately at each visit to find out who they feel safe having present during their appointments. Be careful not to make assumptions about the gender identity or sexual orientation of your clients or the gender identities of their intimate partners.

Asking as part of an IPV assessment

For example, as part of your routine inquiry about IPV, you could say something like:

“Domestic violence is much more than physical abuse. Many people say that their partners abuse them emotionally or call them ‘crazy’ or other demeaning names related to their mental health. Many people say that their abusive partners do or say things to intentionally make them feel like they might be ‘going crazy,’ interfere with their treatment or medication, or do things to undermine them with their friends and family, or with other people they might turn to for help. Have you ever experienced anything like that?” (For more examples, see Appendix A)

If a person does indicate that they are being abused by an intimate partner, you can also ask about how the abuse has affected their mental health, including symptoms of depression, anxiety, PTSD, suicidality, difficulties sleeping or eating, or exacerbations of other mental health conditions.

No? “Okay. If anything like this ever comes up please let me know. We can revisit this at any time.”

Maybe or yes? “I’m really glad you felt like you could share that with me. I believe you and want to offer any support I can to help you feel safer. I want you to know that you’re not alone. Let’s think together about what resources might be helpful to you. Do you have a sense of what might help you feel safer in this moment and after you leave here today?”

Asking as part of a mental health history

Ask about the relationship of mental health symptoms to current abuse and previous trauma including the relationship between a person’s mental health; their overall experience of IPV; as well as previous abuse and other trauma. Talk with patients about:

- **How their feelings of** anxiety and depression, their experiences of PTSD, their difficulties trusting other people, their challenges in managing emotions, or their feelings of paranoia and/or suicidality;
- **Might be related to their experiences of** living in fear, isolation and entrapment, economic control, physical violence, sexual coercion, being stalked, injury-related disability, chronic pain, and/or interpersonal betrayal.
- **For example, depending on what the person has shared with you, you could say:** “I wonder how your feelings of anxiety might be related to being stalked by your partner?”

Ask about the relationship of mental health symptoms to mental health coercion including the relationship between a survivor’s feelings about themselves and others and specific forms of mental health coercion. Talk with patients about:

- **How their** feelings that no one will take them seriously, being afraid to call the police because they will be arrested or committed to a psychiatric unit, being afraid to leave because they won’t be able to retain custody of their children, having suicidal thoughts, feeling terrified, experiencing despair, or doubting their perceptions of reality;
- **Relate to experiences of mental health coercion, such as** being exposed to constant denigration and *gaslighting* (manipulating someone to make them question their memory, experience, or sanity), or to a partner who keeps them from sleeping, prevents them from accessing treatment and medications, undermines their credibility with others, and/or threatens them with commitment, deportation, and/or loss of custody?
- **For example, depending on what the person has shared with you, you could ask:** “I wonder how feeling depressed might be connected to your partner calling you names and treating you with

disrespect?” OR “I wonder how feeling afraid to talk with anyone about what is happening is related to your partner telling you that no one will believe you?”

It is important to remember this might be the first time a person has been asked to reflect on these experiences. You may be the first person they have encountered who has believed them or told them they do not deserve to be harmed. In addition, people may not be able to answer these questions right away or may choose not to. Nonetheless, trying to understand how survivors view their own experiences will increase your ability to support them.

Ask about how their partner responds when they are symptomatic or how their partner treats them when they are feeling depressed, anxious, moody, agitated, and/or having difficulty functioning.

- Is their partner supportive?
- Does their partner criticize and demean them?
- Does their partner use their mental health condition to justify abuse?
- Does their partner try to control their medication or treatment or threaten them with loss of custody because of their mental health symptoms or diagnosis?
- Is their partner only kind to them when they are in distress but abusive or unsupportive when they are feeling good or are not in crisis?

When discussing medication and treatment planning: Ask about how the person thinks their partner might respond and if they have any concerns about their safety.

- Does their partner know they are receiving treatment?
- What is the potential for medication side effects to place them at greater risk for harm (e.g., sedation, agitation, etc.)?
- Does the person need help figuring out how to protect themselves if their abusive partner interferes with their access to treatment, prevents them from taking their medication, or coerces them into taking too much medication?

For additional questions that can be used as part of an assessment, please refer to Appendix A.



ASKING ABOUT SUBSTANCE USE COERCION

IPV Assessment | Substance Use History

Asking About Substance Use Coercion

Similarly, there are a number of ways to raise the issue of substance use coercion.

Asking as part of an IPV assessment

For example, as part of your routine inquiry about IPV, you could say something like:

“Sometimes, people who are being hurt by someone in their life or who have been hurt in the past use alcohol or other drugs to help them cope or get through the day. This includes over-the-counter, prescription, and other kinds of drugs and substances that may or may not be legally available. Many people report their partner makes them use alcohol or other drugs, makes it hard for them to stop or prevents them from stopping, uses their alcohol or other drug use as a way to control them, or does other hurtful things related to their alcohol or other drug use. Does this sound like anything you might be experiencing?” (For more examples, see Appendix A).

No? “Okay, If this ever does come up for you, please let me know. We can revisit this at any time.”

Maybe or yes? “I’m really glad you felt like you could share that with me. I believe you and want to offer any support I can to help you feel safer. I want you to know that you’re not alone. Let’s think together about what resources might be helpful to you. Do you have a sense of what might help you feel safer in this moment and after you leave here today?”

Asking as part of a substance use history

Ask about the relationship of substance use to current and past experiences of IPV and other trauma, including how those experiences have affected the person’s substance use and/or recovery efforts. Talk with patients about:

- **How their experiences of** overdose or withdrawal, stigma related to their substance use, using when they would rather not, and/or their struggles with recovery or relapse;

- **Might be related to** living with fear, isolation, and entrapment; experiencing economic control, physical violence, and/or sexual coercion; being stalked; and/or dealing with injury-related disability, chronic pain, interpersonal betrayal, or trauma-related mental health symptoms?
- **For example, depending on what the person has shared with you, you could say:** “I wonder how using more than you want to might be related to living in constant fear or being told that you don’t matter?” OR “I wonder how your struggle with overdosing might be related to feeling trapped and seeing no way out?”

Ask about the relationship of substance use to substance use coercion including the relationship between the person’s use of substances and specific forms of substance use coercion. Talk with patients about:

- **How their** concerns that they won’t be believed or taken seriously, their reluctance to call the police because they might be arrested, their fears of losing custody being deported, or being blamed for the abuse, and/or their repeated medical or hospital visits;
- **Relate to experiences of substance use coercion, such as:** their partner forcing them to use or use more than they want, forcing them to overdose or go into withdrawal, threatening to use their substance use against them, and/or sabotaging their recovery efforts?
- **For example, depending on what the person has shared with you, you could say:** “I wonder how your fear of losing custody of your children is related to being told that you’re a bad parent for using?” OR “I wonder if your repeated ER visits for overdosing are related to your partner forcing you to use more than you want?”

As noted above, it is important to remember people may not be able to answer these questions right away or may choose not to. Nonetheless, trying to understand how survivors view their own experiences will increase your ability to support them.

Ask about how their partner responds when they are using and/or when they are not using:

- How does their partner treat them when they are using?
- How does their partner treat them when they are sober or not using?
- Does their partner use their substance use to justify abuse?
- Is their partner only kind when they are using but abusive and unsupportive when they are sober or vice versa?
- Has their partner ever tried to prevent them from accessing treatment or medication?

When discussing medication and treatment planning: Ask about how the person thinks their partner might respond to them being on medication or accessing treatment.

- Do they have concerns that their partner might try to make them leave treatment?
- What is the potential for medication side effects to place the survivor at greater risk for harm (e.g., sedation, agitation, etc.)? Factor in the potential side effects of new medications and complications during a transition to medication-assisted treatment (MAT), including increased risk for withdrawal.
- Does the person have concerns about their partner stealing, using, or selling their medications?

Additional strategies for asking about substance use coercion: Most tools can be adapted to incorporate questions about substance use coercion. For example, standard substance abuse screening questions such as the CAGE questionnaire (Ewing, 1984) can be modified to include a survivor's experience of IPV, for example:

1. Have you ever felt like you ought to cut down on your drinking or drug use? Have you ever tried to cut down on your drinking or drug use? Has your partner ever tried to stop you from cutting down on your drinking or drug use?
2. Have you ever been annoyed by someone criticizing your drinking or drug use? Have you ever been made to feel afraid by someone's criticizing your drinking or drug use? Has your partner used your drinking or drug use as a way to threaten you?
3. Have you ever felt guilty about your drinking or drug use? Have you ever felt coerced into drinking, using drugs, or engaging in illegal activities or other behaviors you weren't okay with or that compromised your integrity, and then felt guilty about it?
4. Have you ever had an eye-opener first thing in the morning because drinking or using drugs felt like the only way you could survive or get through the day, steady your nerves, or relieve a hangover? Have you had an eye-opener first thing in the morning because you were forced to drink or use drugs right away?

(Modified from Warshaw & Brasher, 2009 and Ewing, 1984. Criteria for understanding results can be found through Johns Hopkins: http://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/CAGE%20Substance%20Screening%20Tool.pdf)

For additional questions that can be used as part of an assessment, refer to Appendix A.

WHAT NEXT? RESPONDING WHEN SOMEONE DISCLOSES THEIR EXPERIENCES OF COERCION

What Next?

Responding When Someone Discloses Their Experiences of Coercion

Before asking about intimate partner violence (IPV), providers need to be prepared to respond when abuse is disclosed. Knowing how to respond is critical for survivors' safety, and can make it easier to ask questions in ways that let survivors know you are open to their experiences, care about how they feel, and are prepared to respond in ways that helpful—all of which factor into whether or not people are comfortable disclosing abuse.

"I'm really glad that you felt you could share this with me. Let's think about some things that might be helpful to you. If you want, I can help to connect you with an advocate who has experience helping people whose partners are being harmful to them. I can also share some ideas that might help if your partner's behavior is interfering with your mental health or substance use treatment."

As noted above, this tool is meant to supplement other available resources on developing a comprehensive approach for inquiring about and responding to IPV through agency-wide policies, procedures, and protocols in primary care and behavioral health settings. Practice-level components described below include: responding empathically to disclosures, minimizing potential retraumatization in the clinical setting, offering information and perspective, providing brief counseling, strategizing around safety, documenting in ways that are IPV-informed, and making referrals to IPV resources, as relevant.

Many of the suggestions below require flexibility around appointment times and creative clinical strategizing. For example, you might reconfigure your appointment structure (late arrival and no-show

policies) to build in greater flexibility. Often, policies regarding timeliness in medical appointment scheduling are not flexible enough for survivors navigating coercion in their relationships. Does your structure make this harder for survivors? What are the ways you can reduce barriers in scheduling? Can you build in accommodations for survivors experiencing coercion?

The following suggestions are offered as ways to begin these conversations.

RESPONDING WHEN SOMEONE DISCLOSES MENTAL HEALTH COERCION

Responding When Someone Discloses Mental Health Coercion

Specific Things to Keep in Mind

Here are some additional things to consider when a person is experiencing mental health coercion that may affect their ability to engage in treatment:

- ❑ A person's efforts to engage in treatment may be sabotaged by an abusive partner, making it difficult to keep regular appointments. Their efforts to maintain their health and well-being may be undermined, as well. Mental health symptoms related to experiencing violence or coercion can also make it more difficult to keep scheduled appointments. Keeping regularly scheduled appointments can present significant risks to survivors who are actively being stalked – being flexible about rescheduling can be critical for safety.
- ❑ A survivor may be reluctant to seek assistance or contact police out of fear of being arrested, deported, referred to Child Protective Services, losing a job or scholarship, being ostracized by family or community, or not being taken seriously because of their age, gender identity, or sexual orientation.
- ❑ Survivors might be reluctant to engage in treatment knowing their partner might use this against them in a custody battle. Stigma associated with mental health problems makes it less likely that survivors will be believed or seen as capable of parenting. Being diagnosed with certain psychiatric conditions such as schizophrenia or bipolar disorder makes it much more likely that survivors will lose custody of their children (National Council on Disability, 2012).
- ❑ Interpersonal and structural homophobia, biphobia, and transphobia can affect a person's ability to access LGBTQ2SIA (lesbian, gay, bisexual, transgender, two-spirit, intersex, asexual) affirming mental health treatment. Abusive partners often use threats of outing gender or sexual orientation as a means of psychological coercion. Additionally this coercion can be intended to undermine a person's identity or make them question themselves (e.g., an abuser tells their partner they "aren't a real lesbian", or "aren't really transgender").
- ❑ An abusive partner may seem very concerned but may actually be trying to manipulate your

perceptions and control their partner’s treatment. Be wary of involving a partner or family member in treatment without previously (and privately) ascertaining that the person is safe and making sure that the client wants that person involved.

- ❑ Abusive partners often attempt to access medical records to use against survivors in court cases.
- ❑ An abusive partner might interfere with treatment by controlling a survivor’s medication use, such as preventing them from accessing their medication (including withholding meds, selling the meds, taking them themselves), preventing them from taking their medication as prescribed, coercing them to take more than they were prescribed, forcing them to overdose on their meds, leveraging mental health symptoms to get survivors to engage in behaviors they don’t want to engage in, or threatening involuntary commitment and then calling a suicide hotline to garner support for doing so. Abusive partners may also call a survivor an addict for taking medications in the first place.

Brief Counseling

Offer Perspective:

If a person is experiencing mental health coercion, it might be helpful to talk with them about the following – for example, you could say something like:

- ❑ Your partner may try to find other people to agree that your mental health needs give them a right to control or abuse you. This is a tactic to make you feel isolated and further their control over you. By undermining your credibility with other people, your partner makes it much more difficult for you to get support, be believed, and trust your own perceptions.
- ❑ I know there is a lot of stigma associated with psychiatric hospitalizations and/or with taking medication for many years. You have the same right to safety and dignity as anyone who hasn’t had those experiences – regardless of what your partner or society tells you.
- ❑ You mentioned that your partner continually calls you names and deliberately does things to undermine you. Is there someone you can talk with to help you validate your perceptions or offer you additional emotional support?

Discuss Coping Strategies and Emotional Safety:

If a person is experiencing mental health coercion and/or trauma-related mental health symptoms, they might also find it helpful to talk about the ways the abuse is affecting how they think and feel, what helps them cope and survive, and what gets in the way of things that are important to them. One of the ways people who abuse their partners attempt to maintain control is by keeping their partner emotionally off balance and in a constant state of fear. Talking about some of the ways this plays out and some of the things a survivor can do is an important part of emotional safety planning. For example, you could discuss

some of the following:

- Are there things you've noticed about how your partner's behavior is affecting how you think or feel? Some people report feeling hyper alert or on edge most or all of the time or feel like they sometimes "go away" in their heads. Others say they feel down or find they can't always think clearly when they want to, or notice they are having intrusive images or thoughts about traumatic experiences. People also sometimes struggle with nightmares, with falling or staying asleep, or sleeping too much. These experiences are really common. Are you experiencing anything like this?
- What are some of the things you do to help you cope? What have you found to be most helpful? What are the ways that those strategies are working? (Remember that for some people substance use is what they find to be most helpful – be careful not to respond in ways that are shaming or could be experienced as shaming, and recognize the importance of people's coping strategies in helping them to survive).
- Are there ever times when you find that your coping strategies are not working in the ways you want? What have you noticed? How are they not working? What have you been thinking about this? What do you think would be most helpful to you right now?
- Being aware of your feelings can also help you to anticipate situations that are likely to elicit intense responses and make people feel overwhelmed. This awareness can also help you determine how to respond if you find yourself feeling overwhelmed. What are some of the things that help you feel centered and calm?

RESPONDING WHEN SOMEONE DISCLOSES SUBSTANCE USE COERCION

Responding When Someone Discloses Substance Use Coercion

Specific Things to Keep in Mind

Here are some additional things to consider when a person is experiencing substance use coercion that may affect their ability to engage in treatment:

- An abusive partner may sabotage abstinence, recovery, and/or efforts to reduce use.
- Keeping regularly scheduled appointments (e.g., methadone treatment or court ordered substance abuse treatment) can compromise a survivor's ability to avoid the person who is stalking or abusing them.
- Substance use and withdrawal may make it more difficult to keep scheduled appointments. When programs expect or require survivors to be sober in order to continue in or access treatment, it can seriously limit access to care and can be experienced by survivors as punitive.

- ❑ Accessing inpatient treatment for substance abuse can be extremely difficult – even when people have insurance. This is particularly challenging for people navigating ongoing abuse, particularly when their partner is deliberately trying to undermine their sobriety or disrupt their efforts to reduce use. Often, once survivors have accessed treatment, their abusive partner will call repeatedly, harassing them into leaving or otherwise talk them out of staying in treatment.
- ❑ A survivor may be reluctant to seek assistance or contact police out of fear of being arrested, deported, referred to Child Protective Services, losing a job or scholarship, being ostracized by family or community, or not being taken seriously because of their age, gender identity, or sexual orientation.
- ❑ Survivors might be reluctant to engage in treatment knowing their partner might use this against them in a custody battle. Stigma associated with substance use problems makes it less likely that survivors will be believed or seen as capable of parenting. Abusers may accuse their partners of “abandoning their children” if they seek inpatient or residential treatment.
- ❑ Interpersonal and structural homophobia, biphobia, and transphobia can affect a person’s ability to access LGBTQ2SIA (lesbian, gay, bisexual, transgender, two-spirit, intersex, asexual) affirming substance abuse treatment. Abusive partners often use threats of outing their partner’s gender identity or sexual orientation to coerce them to use more than they want or to control their use. Additionally this coercion can be intended to undermine a person’s identity or make them question themselves (e.g., an abuser tells their partner they “aren’t a real lesbian”, or “aren’t really transgender”).
- ❑ An abusive partner might interfere with treatment by controlling a survivor’s medication use, including medication for chronic illness, chronic pain, mental health conditions, and substance abuse. When survivors cannot take the medications that improve their quality of life it can also make it more difficult to access care.
- ❑ An abusive partner might interfere with a survivor’s ability to access their medications (e.g., withholding meds, selling the meds, taking them themselves), preventing them from taking their medication as prescribed, coercing them to taking more than they were prescribed, forcing them to overdose on their medications, leveraging substance use to get survivors to engage in behaviors they don’t want to engage in, or threatening involuntary commitment and then calling a suicide hotline to garner support for doing so. Abusive partners may also call a survivor an addict for taking medications in the first place.
- ❑ The stress associated with leaving an abusive relationship or managing safety while still being exposed to harm, in addition to substance use coercion itself, can lead a person to relapse, use more than they want, or compromise their ability to safety plan.
- ❑ Our own attitudes and expectations about substance use and sobriety might make it more difficult for people to engage with our services (e.g., sobriety requirements vs. harm reduction). Remember that shame can contribute to relapse. Recognizing that relapse is part of the recovery

process for many people is important – particularly if your patient is experiencing substance use coercion.

- ❑ Invest time in training about the use of overdose reversing drugs like naloxone and be ready to train your patients or refer them to training – especially if they are navigating ongoing opioid use or experiencing opioid use-related coercion.

Brief Counseling

Offer Perspective:

If a person is experiencing substance use coercion, it might be helpful to talk with them about the following – for example, you could say something like:

- ❑ Your partner might find other people to agree that your substance use gives them a right to control or abuse you. This is a tactic to make you feel isolated and further their control over you. By undermining your credibility with other people, your partner makes it much more difficult for you to get support, be believed, and trust your own perceptions.
- ❑ It is never your fault when someone harms you if you are drinking or using – regardless of what your partner or society tells you. Your use does not justify violence against you on any level. You deserve to be treated with dignity and respect.
- ❑ You mentioned that your partner regularly tries to get you to use when you don't want to or to use more than you're comfortable with. Is there someone you could call if this is happening to support you?

Discuss Coping Strategies and Emotional Safety:

If a person is experiencing substance use coercion, they might find it useful to talk about the ways that being forced or coerced to use has affected their life, mental health, and well-being. Being forced to use can affect a person's ability to cope with traumatic experiences and coping can become tangled up with using. It can be extremely helpful to explore how this kind of coercion is getting in the way of things that are important to survivors. Additionally, you could strategize together about how to navigate substance use coercion and increase their safety in the short term. For example, you could discuss some of the following:

- ❑ Are there things you've noticed about how your partner's behavior is affecting how you think or feel (e.g., you might notice that you end up using when you don't want to; you feel lethargic, on edge, jumpy, anxious, or out of control; your partner forces you to use until you black out, pass out, or overdose)? Do you find that you don't have the energy to fight them about these issues?
- ❑ What are some of the ways you cope or manage stress? What do you find works the best?

- Have you thought about ways that you can protect yourself while you're still in the relationship? We can talk about some ways to reduce the harm – whether that's by vomiting the extra alcohol or drugs you're forced to take orally, acting more intoxicated to trick your partner, or hiding pills in your mouth until you can spit them out. Are you familiar with medications that reverse opioid overdose?

- Do you find that not using is harder when your partner pressures you to use? Do you worry about what will happen if you refuse to use? Threats and active violence (including calls to child protective services, ICE, employer, school, or the police) are really common ways people coerce their partners into using. Do you want to brainstorm some strategies that might increase your safety and reduce harm?

SAFETY PLANNING: STRATEGIZE ABOUT WAYS TO ACCESS TREATMENT AND SERVICES

Safety Planning: Strategize About Ways to Access Treatment and Services

Given what you now know about the specifics of mental health and substance use coercion, here are some helpful strategies for creating a safety plan (a personalized plan to support someone experiencing harm or danger with attentiveness to physical and emotional safety) with both types of coercion in mind:

- ❑ Discuss safe times and places for a survivor to place or receive calls, to send bills, and/or to come to appointments.
- ❑ Discuss options for managing medication safely, if a person's partner controls their medication. For example you could say, *"Let's talk about a safe place for you to leave medications where you could still access them as prescribed."* This is particularly relevant if the person is receiving Medication Assisted Treatment (MAT) for opioid or alcohol recovery, or if the person has been prescribed opioids for chronic pain.
- ❑ Discuss whether there are safe places the person has access to (work, school, friend, family, or sponsor's house, spiritual or community-based organization), where they could receive phone calls, bills, EOBs, or other information. If not, discuss strategies to make sure pharmacies and treatment providers do not call or send mail to the home or to the primary insurance holder if it is the abusive partner. While this does not always work, inform survivors that they can request that bills, explanation of benefits, and other information related to treatment not be sent to their home.
- ❑ Discuss safe strategies for keeping appointments. For example, if the person is working, at school, and/or can spend some time out of the house, could time be built in (at lunch break, in between classes, right before work, etc.) for a telephone or in-person appointment?
- ❑ Discuss safe strategies for staying in treatment when an abusive partner is pressuring the person to leave.

- ❑ Discuss whether keeping regular appointments (e.g., methadone treatment) raises concerns about being stalked. Discuss ways to stagger appointment times or try switching to another form of treatment (e.g., buprenorphine, naltrexone). Explore the possibility of switching to probuphine or other long acting injectable medications as appropriate, especially if taking daily medications is disrupted or made impossible by an abusive partner, or if their abusive partner is stealing their meds to sell or use themselves.
- ❑ Discuss any legal documents that enable the abuser to have control over your client's care (e.g., power of attorney, advance directives). Make a plan to amend those documents so that the person listed is someone your client trusts.
- ❑ Discuss privacy concerns related to documentation and electronic health records (EHR), clarify the ways that their health records can be accessed and by whom, discuss what steps and safety measures can be taken to protect sensitive information, and thoroughly discuss the pros and cons of releasing information to other parties as part of the informed consent process.
- ❑ Discuss referrals to IPV professionals. One of the most useful things you can do is to make a warm referral to a community IPV advocate or someone in your practice setting who has expertise on IPV and can help with more detailed safety planning. Make sure to have a list of resources available in your practice setting.
- ❑ Discuss referrals to substance use and mental health professionals who are sensitive to both trauma and IPV, and are knowledgeable about culture, gender, and sexuality. This is especially helpful for women, genderqueer, and transgender clients who often struggle to find affirming care and inpatient treatment options.
- ❑ Ask about what childcare supports they might need to be able to access treatment, which may be of particular concern if inpatient options are being considered.

And, of course create a safe environment to talk with patients about their relationships and what they want, what they have tried, what their concerns are, what obstacles they face, and what might be most helpful to them and their children. If your patient is a parent, it will be important to consider their children in offering treatment options. Coordinating care with other trusted professionals in your patient's life can make a significant difference in people getting the support they need.

ADDITIONAL CONSIDERATIONS ABOUT SAFETY, PRIVACY AND CONFIDENTIALITY: DOCUMENTATION AND ELECTRONIC HEALTH RECORDS (EHRs)

Additional Considerations About Safety, Privacy and Confidentiality: Documentation and Electronic Health Records (EHRs)

Documentation with Mental Health or Substance Use Coercion in Mind

While confidentiality is generally well protected within the health, mental health, and substance use fields, there are particular issues to be aware of when working with survivors of intimate partner violence (IPV). Any information that becomes available to a person who abuses their partner can increase that person's danger, including their location, the fact that they are seeking treatment, and/or that they disclosed the abuse. At the same time, thoughtful documentation of IPV and its effects can greatly benefit survivors who want to use records to prove that the abuse occurred, bolster their credibility, or provide evidence of their ability to be a good parent. It is important to be cognizant that records can be subpoenaed to support an abuser's case against your client. Therefore, it is important to document the traumatic effects of abuse and coercion related to substance use or mental health, as well as survivors' efforts to take care of their health and mental health and to protect their children.

Careful documentation, regardless of diagnosis, can be helpful to a survivor in court, depending on their legal representation. Be mindful of how information about diagnoses and medication might be used against a survivor in a custody battle. According to the National Council on Disability (2012), parents with psychiatric disabilities have their children removed between 70-80% of the time. This is often due to stigma, institutional ableism, and the inaccurate belief that people with disabilities are incapable of being good parents, which is commonly exploited by people who abuse their partners.

Best Practices for Documentation with Mental Health and Substance Use Coercion in Mind:

- Document the relationship of mental health symptoms or substance use to the abuse in general (e.g., symptoms of PTSD, depression, symptoms aggravated by experiencing abuse, etc.).
- Document the relationship of mental health symptoms or substance use to specific forms of mental health or substance use coercion.
- Document any attempt by the abusive partner to control your perceptions of the survivor's experience leading up to your interaction with them. It is important not to be fooled by an abuser who might appear calmer and more collected than the person they have been abusing.
- Document efforts on the part of the abusive partner to control medication or treatment, and strategies to address this.
- Document the potential for mental health symptoms and/or problematic substance use to subside once a survivor has access to safety, resources, and support.
- Describe the survivor's strengths, coping strategies, ability to care for their children, and the efforts made to protect them. Indications of their parenting ability and their children's attachment to them (e.g., observations of interactions with their children, discussions that demonstrate attunement and concern) should also be clearly documented.

It is important to recognize the appropriateness of a survivor's anger toward an abusive partner and their reluctance to expose their children to a violent abusive parent. Survivors are often penalized in these situations for being the less cooperative parent. Conversely, in states with Failure to Protect laws, survivors are often unjustly penalized for failure to limit contact with their abusive partner. Abusers frequently use custody battles and visitation as ways to control a partner who is attempting to leave. Prolonged custody battles are particularly devastating to survivors and their children. Abusers often continue to drag their partners to court, depleting their legal funds and threatening the safety and well-being of their children.

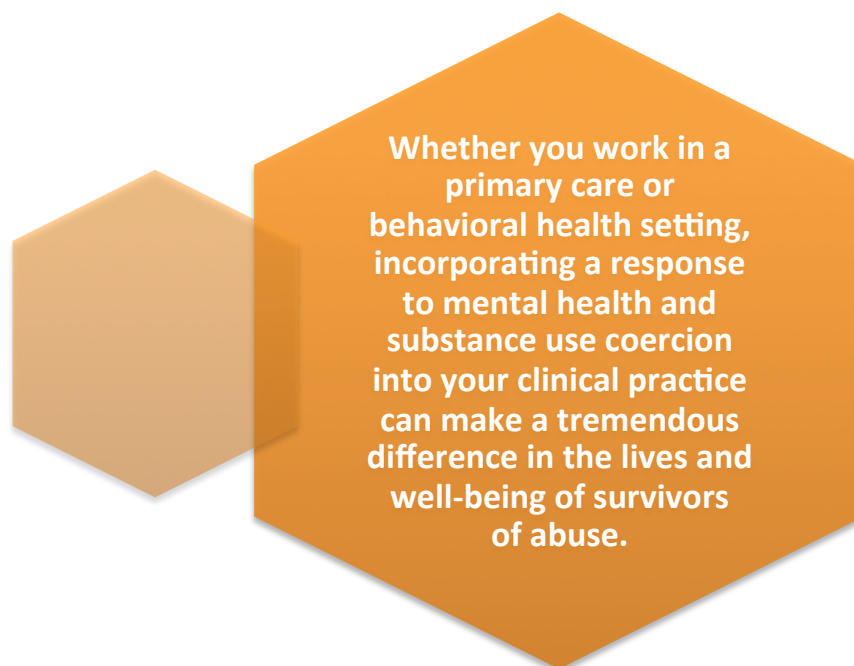
Privacy and Electronic Health Records

The adoption of Electronic Health Records (EHRs) has presented opportunities and challenges for improving the behavioral health care system response to intimate partner violence (IPV). When using EHRs, providers should be aware of mechanisms that are available within their practice setting for keeping mental health or substance use treatment information private or to ensure that patients have a choice about who can have access to that information, except in cases of emergency. Providers should discuss the possible risks of disclosure with the person they are working with, including risks that the data

may be accessed by an abusive partner who works in a health care setting or who coerces their partner to access their records online, as well as by providers who are not sensitive to these issues. Providers should discuss whether there is any risk that an abuser's legal team may try to subpoena the information in the context of a custody proceeding. Good documentation and informed consent can help mitigate issues when records are subpoenaed; however, ensuring that sensitive information is protected is critical given the stigma that continues to be associated with these issues and the risks posed by an abusive partner learning that the survivor is seeking help.

Conclusion

Whether you work in a primary care or behavioral health setting, incorporating a response to mental health and substance use coercion into your clinical practice can make a tremendous difference in the lives and well-being of survivors of abuse. Your efforts to ask routinely; create safe opportunities for people to discuss their experiences; respond with compassion, knowledge, and care; work with survivors to develop strategies for emotional and physical safety; document in ways that support survivors in meeting their needs; and facilitate access to mental health, substance abuse, and intimate partner violence services are critical to the provision of good clinical care. We appreciate you taking the time to incorporate this important information into your clinical work. For additional information and support, please contact the National Center on Domestic Violence, Trauma & Mental Health.



KEY ELEMENTS FOR RESPONDING TO MENTAL HEALTH AND SUBSTANCE USE COERCION IN CLINICAL PRACTICE

Ensure all clinical and non-clinical staff receive training on trauma and IPV.

Ask routinely: Incorporate questions about coercion and IPV into routine intake and assessment

Know how or when your state requires reporting of IPV, and disclose your reporting obligations before asking about abuse

Validate perceptions, acknowledge impact, and express concern.

Address immediate and ongoing safety needs including onsite security, psychiatric advance directives, and family involvement in treatment.

Work in partnership with survivors to develop safe strategies for addressing coercive behaviors and their effects.

Provide access to print and online resources on trauma and IPV.

Document in ways that link symptoms and ability to participate in treatment to the abuse; document efforts to protect and care for children.

Provide linkages or “warm referrals” to community IPV resources, including legal services and hotlines, and/or provide IPV counseling onsite.

Incorporate IPV counseling and safety planning into clinical treatment and other services including medication decisions; overdose and relapse prevention; and mental health, substance abuse, and trauma treatment.

Discuss confidentiality, and information sharing and options to protect sensitive information vis-à-vis EHRs, billing, EOBs and referrals.

Provide ongoing support and follow-up.

Incorporate responses to IPV and other trauma into performance improvement plans, including input from people experiencing IPV.

Ensure that services are both IPV- and trauma-informed.

Be aware of one’s own responses and need for consultation and support.

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APPENDIX A :: ADDITIONAL QUESTIONS TO CONSIDER WEAVING INTO MORE IN-DEPTH ASSESSMENT OR DISCUSSION IF ABUSE IS DISCLOSED

The questions below provide examples of some of the things that survivors experience in abusive relationships where mental health and substance use coercion are present. They are not intended to be used as a checklist, but rather as questions that can be folded into a more in-depth conversation and to let survivors know you are aware of the kinds of things they may have experienced. Since asking about abuse and trauma can in itself be traumatizing, informing people of what will be asked and why, checking to see if they are comfortable proceeding, attending to signs (such as increased anxiety or dissociation) that prior traumatic experiences are being triggered, and ensuring that they have someone to talk with should the need arise after they leave, are critical. Over time, you will learn from your clients what is most helpful.

Additional Questions to Consider Weaving into a More In-Depth Mental Health Assessment or as Part of a More In-Depth Discussion if Abuse is Disclosed

- Does your partner intentionally do things to make you feel “crazy” or like you are “losing your mind”?
- Does your partner tell you that you are lazy, stupid, crazy, or a bad parent because of a mental health condition?
- Does your partner ever keep you up all night or try to prevent you from sleeping?
- Has your partner blamed you for the abuse by saying you’re the one who is crazy?
- Does your partner tell you no one will believe what you say because of your mental health condition?
- Has your partner ever used your mental health condition to undermine or humiliate you with other people?
- Has your partner ever threatened that you will lose custody of your children because of your mental health?
- Has your partner ever done things to cause your mental health symptoms to get worse?
- Has your partner ever tried to prevent or discourage you from accessing mental health treatment or taking your prescription medication?
- Has your partner ever tried to control your prescription medication (such as by forcing you to overdose, giving you too much or too little medication, or preventing you from taking it at all)?
- Has your partner ever had you take too much medication as a means of sexual coercion or to get you to do something you might not otherwise do?
- Does your partner restrict or interfere with your ability to speak for yourself with doctors or mental health professionals? Has your partner ever tried to sabotage your work or school by disclosing your diagnosis or falsely

claiming you are risk to yourself or others?

- Has your partner ever threatened or tried to have you committed to an inpatient psychiatric unit?
- Are there other things your partner has done that you'd like to talk with me about?
- What have you noticed about how this is affecting you? What can I do to support you?

Additional Questions to Consider Weaving into a More In-Depth Substance Use Assessment or a More In-Depth Discussion if Abuse is Disclosed

- Do you ever use alcohol or other drugs to numb out, feel better, forget, or to be able to function?
- Has your partner ever made you use alcohol or other drugs, made you use more than you wanted, or threatened to harm you or leave you if you didn't use?
- Does your partner control your access to alcohol or other drugs, and then use that control to manipulate you or make you do things that you don't want to do?
- Does your partner justify name-calling, criticizing, belittling, and undermining you because of your alcohol or drug use?
- Has your partner told you that you are to blame when they treat you badly, abuse you, or sexually assault you—saying it's your fault or you deserved it because you drink alcohol or use other drugs?
- Has your partner ever forced or coerced you into doing something illegal (e.g., dealing, stealing, trading sex for drugs) or other things you felt uncomfortable with in order to obtain alcohol or other drugs?
- Have you ever been afraid to call the police for help because your partner said you would be arrested for being high or that your children would be taken away?
- Has your partner ever threatened that you would lose custody of your children because of your alcohol or drug use?
- Has your partner ever tried to manipulate you by making you go into withdrawal?
- Has your partner ever stopped you from cutting down or quitting alcohol or other drugs when you wanted to, or made it harder for you to do so?
- Has your partner ever prevented you from attending a recovery meeting, interfered with your treatment, or sabotaged your recovery in other ways?
- Has your partner ever used alcohol or other drugs as a way to get you to engage in sexual activities you were uncomfortable with or did not consent to?
- Does your partner force you to use when they use? Have they ever spent all of your money on drugs or alcohol without your consent? Does your partner's use affect your use?
- Has your partner ever tried to sabotage your work or school by disclosing your diagnosis or falsely claiming you are risk to yourself or others?
- Are there other things your partner has done that you'd like to talk with me about?
- What have you noticed about how this is affecting you? What can I do to support you?

APPENDIX B :: ADDITIONAL RESOURCES AND REFERENCES

National Center on Domestic Violence, Trauma & Mental Health

WWW.NATIONALCENTERONDVTRAUMAMH.ORG

For additional resources on the intersection of intimate partner violence, trauma, mental health, and substance use, see:

- ❑ **Mental Health and Substance Use Coercion Surveys: Report from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline**
[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/2014/09/MENTAL-HEALTH-AND-SUBSTANCE-USE-COERCION-SURVEYS-REPORT-NOW-AVAILABLE/](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/2014/09/MENTAL-HEALTH-AND-SUBSTANCE-USE-COERCION-SURVEYS-REPORT-NOW-AVAILABLE/)
- ❑ **A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors**
[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/NCDVTMH-REVIEW-OF-TRAUMA-SPECIFIC-TREATMENT-IN-THE-CONTEXT-OF-DOMESTIC-VIOLENCE/](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/NCDVTMH-REVIEW-OF-TRAUMA-SPECIFIC-TREATMENT-IN-THE-CONTEXT-OF-DOMESTIC-VIOLENCE/)
- ❑ **Trauma in the Context of Domestic Violence**
[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/2014/10/NCDVTMH-GUEST-EDITS-SPECIAL-ISSUE-OF-SYNERGY-IN-HONOR-OF-DV-AWARENESS-MONTH/](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/2014/10/NCDVTMH-GUEST-EDITS-SPECIAL-ISSUE-OF-SYNERGY-IN-HONOR-OF-DV-AWARENESS-MONTH/)
- ❑ **Trauma-Informed Care for Mental Health Professionals**
[HTTP://ATHEALTH.COM/TRAUMA-INFORMED-CARE-FOR-MENTAL-HEALTH-PROFESSIONALS/](http://ATHEALTH.COM/TRAUMA-INFORMED-CARE-FOR-MENTAL-HEALTH-PROFESSIONALS/)
- ❑ **Substance Use/Abuse in the Context of Domestic Violence, Sexual Assault, and Trauma**
[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/SUBSTANCE-USEABUSE-IN-THE-CONTEXT-OF-DOMESTIC-VIOLENCE-SEXUAL-ASSAULT-AND-TRAUMA/](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/PUBLICATIONS-PRODUCTS/SUBSTANCE-USEABUSE-IN-THE-CONTEXT-OF-DOMESTIC-VIOLENCE-SEXUAL-ASSAULT-AND-TRAUMA/)
- ❑ **Relationship Between Intimate Partner Violence and Substance Use: Applied Research Paper**
[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/2016/03/NEW-RESOURCE-THE-RELATIONSHIP-BETWEEN-INTIMATE-PARTNER-VIOLENCE-AND-SUBSTANCE-USE-AN-APPLIED-RESEARCH-PAPER/](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/2016/03/NEW-RESOURCE-THE-RELATIONSHIP-BETWEEN-INTIMATE-PARTNER-VIOLENCE-AND-SUBSTANCE-USE-AN-APPLIED-RESEARCH-PAPER/)
- ❑ **Mental Health Treatment for Survivors of Intimate Partner Violence**
[HTTP://WWW.NATIONALCENTERDVTRAUMAMH.ORG/WP-CONTENT/UPLOADS/2015/10/MITCHELL-CHAPTER-24.PDF](http://WWW.NATIONALCENTERDVTRAUMAMH.ORG/WP-CONTENT/UPLOADS/2015/10/MITCHELL-CHAPTER-24.PDF)

To assist in accessing local, state, tribal, and territory DV services, providers, resources, and crisis intervention services see:

- ❑ For 24/7 information for providers, survivors in crisis, and survivors looking for services see:
National Domestic Violence Hotline: WWW.THEHOTLINE.ORG or call 1-800-799-SAFE (7233);
 TTY: 1-800-787-3224
- ❑ **List of United States State and Territory Coalitions**

[HTTPS://NNEDV.ORG/CONTENT/STATE-U-S-TERRITORY-COALITIONS/](https://nnedv.org/content/state-u-s-territory-coalitions/)

❑ **Alaska Native Women’s Resource Center**

[HTTP://WWW.AKNWRC.ORG](http://www.aknwrc.org)

❑ **The Asian Pacific Islander Institute on Gender-Based Violence**

[HTTPS://WWW.API-GBV.ORG](https://www.api-gbv.org)

❑ **The National Indigenous Women’s Resource Center**

[WWW.NIWRC.ORG](http://www.niwrc.org)

❑ **The National LGBTQ Institute on IPV**

[HTTP://LGBTQIPV.ORG](http://lgbtqipv.org)

❑ **Ujima: The National Center on Violence Against Women in the Black Community**

[HTTPS://UJIMACOMMUNITY.ORG/](https://ujimacommunity.org/)

For information about incorporating a trauma-informed approach in health care and behavioral health settings, see:

❑ For additional information on responding to IPV in healthcare settings, see:

Health Cares About IPV: [WWW.HEALTHCARESABOUTIPV.ORG](http://www.healthcaresaboutipv.org)

❑ **SAMHSA TIP 57: Trauma-Informed Care in Behavioral Health Settings**

[HTTPS://STORE.SAMHSA.GOV/PRODUCT/TIP-57-TRAUMA-INFORMED-CARE-IN-BEHAVIORAL-HEALTH-SERVICES/SMA14-4816](https://store.samhsa.gov/product/tip-57-trauma-informed-care-in-behavioral-health-services/sma14-4816)