INFORMATION MEMORANDUM

TO: State Mental Health and Substance Use Disorder Treatment Directors
State Family Violence Prevention and Services Act (FVPSA) Administrators

SUBJECT: The Intersection of Domestic Violence, Mental Health, and Substance Use

PURPOSE:

(1) To provide State Mental Health and Substance Use Disorder Treatment Directors with information about domestic violence (DV), including information about the prevalence of DV among people receiving services in mental health and substance use disorder treatment settings. Also the impact of DV on substance use and mental health, as well as information about available training, resources, and potential partners for developing effective responses to individuals and families experiencing the traumatic effects of DV.

(2) To provide State Family Violence Prevention and Services Act (FVPSA) Administrators with information about the mental health and substance use effects of DV and about available training, resources, and potential partners for supporting DV programs in responding effectively to survivors, youth, and children experiencing the mental health and substance use-related consequences of DV.

(3) To encourage collaboration between the DV service system and the mental health and substance use disorder treatment and peer recovery systems.

BACKGROUND

Domestic violence, substance use, and mental health are all issues with major health consequences that impact a large number of people across the country. While these issues have historically been addressed separately, many people seeking services in DV programs also require mental health or substance use services. Likewise, significant numbers of persons in behavioral health programs have experienced or are experiencing DV. Increasing collaboration and coordination between systems providing services to these populations can help ensure that all individuals and families have the support they need to overcome these issues.

What is Domestic Violence? When generally defined, DV is a pattern of coercive behavior, including acts or threatened acts, that are used by a perpetrator to gain power and control over a current or former spouse, intimate partner, dating partner, or person with whom the perpetrator shares a child or household in common. This behavior includes, but is not limited to, physical or sexual violence, emotional and/or psychological intimidation, verbal abuse, stalking, economic control, harassment, threats, physical intimidation, or injury. For state specific definitions of domestic violence, search the state statutes database on the Child Welfare Information Gateway.

(While the term "domestic violence" is commonly used by many state agencies and human services professionals, the term "intimate partner violence" (or IPV) is often used by researchers, clinical professionals, and some federal agencies to refer to this pattern of behavior. For the purpose of this memorandum, the terms can be used interchangeably.)

The Centers for Disease Control and Prevention (CDC) reports that, on average, 24 people per minute are victims of stalking, physical violence, or rape by an intimate partner in the United States.[1] In addition, the CDC estimates that over one-third (36.4 percent) of all women have experienced stalking, physical violence, or rape, and over one-third (36.4 percent) have experienced psychological aggression by an intimate partner during her lifetime.[2] While DV affects every community, people living in poverty experience higher rates of abuse. According to the CDC (2018), 21.4 percent of women have experienced severe physical violence by an intimate partner, while 14.9 percent of men have experienced the same at some time.

There Are High Rates of Domestic Violence Among People Seen in Mental Health and Substance Use Disorder Treatment Settings. Women seen in mental health settings report high rates of DV (30 percent of women in outpatient settings, and 33 percent in inpatient settings).[3] Other studies have reported rates of lifetime prevalence of severe DV among psychiatric in-patients ranging from 30 percent to 60 percent. Lower rates were reported for men when prevalence is reported by gender.[4] In addition, general population studies have found higher rates of DV among people experiencing a serious mental illness and studies of women experiencing a serious mental illness have found high rates of DV.[5] [6] [7] Similarly, studies conducted in substance use disorder treatment settings have also found high rates of DV victimization among women accessing those services (47 percent-90 percent lifetime, 31 percent-67 percent within the past year).[8] [9] [10] [11]

---

[1] Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

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

[3] Oram, S., Trevillion, K., Feder, G., & Howard, L. M. (2013). Prevalence of experiences of domestic violence among psychiatric patients: Systematic review. *The British Journal of Psychiatry, 202*(2), 94-99.

[4] Howard L, Trevillion K, Khalifeh H, Woodall A, Agnew-Davies R, Feder G (2010). Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychological Medicine 40, 881–893.

[5] Khalifeh, H., Oram S., Trevillion K., Johnson S., Howard, L.M. Recent intimate partner violence among people with chronic mental illness: findings from a national cross-sectional survey. Br J Psychiatry. 2015 Sep;207(3):207-12.

[6] Friedman SH1, Loue S. Incidence and prevalence of intimate partner violence by and against women with severe mental illness. J Womens Health (Larchmt). 2007 May;16(4):471-80.

[7] González Cases J1, Polo Usaola C, González Aguado F, López Gironés M, Rullas Trincado M, Fernández Liria A. Prevalence and characteristics of intimate partner violence against women with severe mental illness: a prevalence study in Spain. Community Ment Health J. 2014 Oct;50(7):841-7.

[8] Downs, W. R. (2001). *Alcohol problems and violence against women: Report of summary findings (Doc. No. 188267),* Washington, DC: U.S. Department of Justice.

[9] 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

[10] Schneider, R., & Burnette, M. (2009). Prevalence and correlates of intimate partner violence victimization among men and women entering substance use disorder treatment. *Violence and Victims, 24*(6), 744–756. doi:10.1891/0886-6708.24.6.744.

[11] Wagner, K. D., Hudson, S. M., Latka, M. H., Strathdee, S. a, Thiede, H., Mackesy-Amiti, M. E., & Garfein, R. S. (2009). The effect of intimate partner violence on receptive syringe sharing among young female injection drug users: An analysis of mediation effects. *AIDS and Behavior, 13*(2), 217–24. doi:10.1007/s10461-007-9309-5

Domestic Violence Has Significant Mental Health and Substance Use Effects. Research conducted over the past 35 years has consistently shown that being victimized by an intimate partner increases a person's risk for depression, post-traumatic stress disorder (PTSD), substance use disorders, eating disorders, insomnia, and suicidality, as well as a range of chronic health conditions.[12] [13] [14] [15] [16] Other studies have found high rates of depression, PTSD, suicidality and substance use problems among women in DV shelters.[17] [18] In addition, exposure to ongoing abuse can exacerbate symptoms and precipitate mental health crises, making it more difficult to access resources and increasing an abusive partner's control over victims' lives.[19] For some survivors and their children, these resolve with safety and support, while for others, trauma-informed mental health and substance use disorder treatment play a critical role in their healing and recovery.

Domestic Violence Is Often Targeted Toward Undermining a Partner's Mental Health or Substance Use Disorder Treatment and Recovery. In addition to experiencing the traumatic psychophysiological effects of abuse, many survivors experience coercive tactics specifically related to their mental health or use of substances as part of a broader pattern of abuse and control. For example, while DV survivors may use substances to cope with trauma,[20] abusive partners may also force or coerce them to use.[21] A study by the National Domestic Violence Hotline found disturbingly high rates of abuse specifically targeting women's mental health and/or substance use. Survivors reported that their abusive partners intentionally undermined their sanity or sobriety; controlled their access to medication; sabotaged their treatment and recovery efforts; and undermined their credibility with friends, family, helping professionals, and the courts. At the same time, experiencing a mental health or substance use disorder, places people at greater risk for being controlled by an abusive partner.[22] Stigma associated with substance use and mental illness contributes to the effectiveness of these abusive tactics and can

---

[12] Phillips H., Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL 2014 http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf

[13] Dillon, G., Hussain, R., Loxton, D. Rahman, S. Mental and physical health and intimate partner violence against women: A review of the literature. International Journal of Family Medicine. 2013:313909.

[14] Devries, K.M., Mak J. Y., Bacchus, L.J., Child, J. C., Falder, G., et al. Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. PLoS Medicine, 2013. 10(5). 21001439

[15] Nathanson A.M., Shorey R.C., Tirone V., Rhatigan D.L. The Prevalence of Mental Health Disorders in a Community Sample of Female Victims of Intimate Partner Violence. Partner Abuse. 2012; 3(1):59-75

[16] Trevillion K, Oram S, Feder G, Howard LM. Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. PLoS One. 2012;7(12)

[17] Golding, J.M. (2000). Unpublished manuscript. Chicago: Domestic Violence and Mental Health Policy Initiative.

[18] Helfrich CA, Fujiura GT, Rutkowski-Kmitta V. Mental health disorders and functioning of women in domestic violence shelters. J Interpers Violence. 2008 Apr;23(4):437-53.

[19] Howard L, Trevillion K, Khalifeh H, Woodall A, Agnew-Davies R, Feder G (2010). Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychological Medicine 40, 881–893.

[20] Bennett, L., & O'Brien, P. (2007). Effects of coordinated services for drug-abusing women who are victims of intimate partner violence. *Violence against Women, 13*(4), 395-411.

[21] Warshaw, C. et al. (2014). Mental Health and Substance Use Coercion Surveys Report from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline (pp. 1-26).

[22] Ibid. Warshaw et. al, (2014)

create additional barriers for survivors and their children when they try to seek help.

Domestic Violence Can Impact Children and Parenting. Additionally, people who perpetrate DV often actively try to undermine their partners' relationships with their children, creating risks for children's development and their physical and mental health.[23] While exposure to DV can impact children's physical, psychological, and emotional well-being and increase the risk for child welfare involvement, particularly when DV is compounded by parental substance use or mental health conditions, research consistently shows that attachment to the non-abusive primary caregiver is what is most protective of children's resilience and development.[24] [25] [26] Research noted by the Child Welfare Information Gateway[27] has also shown that prevention and early intervention efforts are effective in reducing child abuse and DV. Understanding the dynamics of DV is critical to supporting children and families—particularly in the face of abusive behavior targeted at a partner's substance use, mental health, or parenting.

OPPORTUNITIES FOR COLLABORATION

The Role of the Mental Health and Substance Use Disorder Treatment Systems. Understanding DV and its intersection with mental health and substance use is important for clinicians working with individuals who may have experienced DV in the past as well as working with individuals who are still at risk. Knowing how to respond appropriately when a person is in immediate danger or contending with an abusive, controlling partner is critical to supporting the safety and well-being of both survivors and their children. While most clinicians report that they would like additional training and resources on identifying and addressing DV, many also report that they have not received training on how to ask or respond to DV in the context of behavioral health treatment.[28]

A 2012 national survey conducted by the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) in partnership with the National Association of State Mental Health Program Directors (NASMHPD) found that only 17 of the 38 states that responded had engaged in some type of state-level coordination with DV organizations. Of these, 13 had engaged in cross-training efforts but only 9 had developed policies, protocols, or guidelines for incorporating questions about domestic violence into mental health intake and assessments; 8 had developed policies, protocols, or guidelines for incorporating referrals to DV agencies into treatment planning; and 3 had engaged in efforts to provide rapid access to mental health services for survivors referred from domestic violence programs. The majority (34 states), however, indicated a strong interest in further coordination and/or training on these issues.

---

[23] Graham-Bermann, S. & Levendosky, A. (Eds.) (2011). *How intimate partner violence affects children: Developmental research, case studies, and evidence-based intervention.* Washington, DC: APA.
[24] Children and Domestic Violence Fact Sheet. (2014)
http://www.nctsn.org/sites/default/files/assets/pdfs/childrenanddv_factsheet_1.pdf
[25] Osofsky, J. D. (1999). The impact of violence on children. The Future of Children: Domestic Violence and Children, 9 (3), 38.
[26] Wyman, P. A., Cowen, E. L., Work, W. C., Hoyt-Meyers, L., Magnus, K. B., & Fagen, D. B. (1999). Caregiving and developmental factors differentiating young at-risk urban children showing resilient versus stress-affected outcomes: A replication and extension. Child Development, 70, 645–659.
[27] Available at https://www.childwelfare.gov/topics/systemwide/domviolence/prevention/.
[28] Ibid. Howard et. al, 2010.

(See: http://www.nationalcenterdvtraumamh.org/2014/10/now-available-state-mental-health-administrators-survey-report/.)

Over the past decade, state mental health and substance use disorder treatment systems, with support from the federal level, have been successfully implementing trauma-informed and trauma-specific treatment services, with substantial advancement in these areas. However, while awareness of trauma has increased in recent years, trauma in the context of ongoing DV remains a largely unaddressed issue.

There are currently numerous evidence-based treatments for PTSD.[29] [30] Yet, the majority of these focus on trauma that occurred in the past. For those experiencing ongoing DV, responding to trauma raises an additional set of concerns, particularly when the trauma is unremitting and symptoms reflect a response to ongoing danger and coercive control. Additionally, they may have partners who discourage or prevent them from attending treatment, prevent them from taking medication as prescribed, and/or force or coerce them to use substances when they are in recovery.

While evidence-based treatments designed specifically for persons experiencing DV are still limited, there are several evidence-based interventions that have shown efficacy in reducing depression and PTSD among survivors of DV (although very few that have been specifically designed for or evaluated for efficacy with survivors from culturally specific or historically marginalized communities.)[31] [32] There are also several substance use disorder treatment approaches that have been adapted for DV survivors[33] [34] [35] as well as a number of evidence-based treatments for children exposed to DV.[36]

---

[29] Bisson, Roberts, Andrew, Cooper, & Lewis 2013; Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *The Cochrane Library, 12*. DOI: 10.1002/14651858.CD003388.pub4

[30] Difede, J., Olden, M., & Cukor, J. (2014). Evidence-based treatment of post-traumatic stress disorder. *Annual Review of Medicine, 65*, 319-332.

[31] Arroyo, K., Lundahl, B., Butters, R., Vanderloo, M., & Wood, D. S. (2015). Short-term interventions for survivors of intimate partner violence: A systematic review and meta-analysis. *Trauma, Violence & Abuse*. DOI: 10.1177/1524838015602736

[32] Warshaw, C., Sullivan, C.M., Rivera, E.A. (2013). A systematic review of trauma-focused interventions for domestic violence survivors. Chicago: NCDVTMH.

[33] Cohen, L. R., Field, C., Campbell, A. N., & Hien, D. A. (2013). Intimate partner violence outcomes in women with PTSD and substance use: A secondary analysis of NIDA Clinical Trials Network "Women and Trauma" Multi-site Study. *Addictive Behaviors, 38*(7), 2325-2332. DOI: 10.1016/j.addbeh.2013.03.006; https://effectivehealthcare.ahrq.gov/topics/ptsd-adult-treatment-update/research-protocol

[34] Gilbert, L., El-Bassel, N., Manuel, J., Wu, E., Go, H., Golder, S. & Sanders, G. (2006). An integrated relapse prevention and relationship safety intervention for women on methadone: Testing short-term effects on intimate partner violence and substance use. *Violence and Victims, 21*(5), 657-672. DOI: 10.1891/0886-6708.21.5.657

[35] Myers, U. S., Browne, K. C., & Norman, S. B. (2015). Treatment engagement: Female survivors of intimate partner violence in treatment for PTSD and alcohol use disorder. *Journal of Dual Diagnosis, 11*(3-4), 238-247. DOI: 10.1080/15504263.2015.1113762

[36] *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* (National Child Traumatic Stress Network, 2008; *Evidence-based & Evidence-informed Programs: Prevention Program Descriptions Classified by CBCAP Evidence-based and Evidence-informed Categories* (FRIENDS National Resource Center for Community-Based Child Abuse Prevention [CBCAP], 2009); *Evidence-Based Practices for Children Exposed to Violence: A Selection from Federal Databases* (Department of Health and Social Services, 2011)

Responding to the needs of persons exposed to DV in mental health and substance use disorder treatment settings involves a combination of DV-specific interventions that can be incorporated into any treatment modality and, for some survivors, trauma-specific treatment that has been specifically adapted for survivors of DV.[37] Resources on all of these approaches are listed below.

The Need for Collaboration with State and Local Domestic Violence Service Systems. The uniqueness of the challenges faced by survivors of DV underscores the need for collaboration among the mental health, substance use disorder treatment, and DV fields. Responding effectively to individuals experiencing ongoing DV as part of their mental health and substance use disorder treatment requires not only specific training and technical assistance but also ongoing partnerships with local, state, and national DV organizations to help address the many complex issues they face in trying to free themselves from violence and recover from its traumatic effects.

DV survivors often face a number of other challenges that DV programs are highly experienced in addressing. These include needs related to in-depth safety planning; support for interfacing with the criminal and civil legal systems, including obtaining orders of protection and dealing with contested custody cases; assistance with economic supports, job training, and housing; services for children, including services that support parenting; ongoing counseling and support groups; emergency and transitional housing programs; programs for teens; community outreach; and prevention programs and systems advocacy.

DV programs vary in their level of experience in working with survivors who are experiencing mental health and substance use disorders in-house. However, those that have been able to form partnerships with local mental health and substance use disorder treatment providers have been highly successful in serving survivors dealing with these complex concerns.[38]

ACF and SAMHSA Commitment. ACF and SAMHSA are committed to supporting state mental health and substance use disorder treatment directors, as well as state FVPSA administrators and leaders in the DV field, to forge effective partnerships, to share expertise, and to develop collaborative efforts to serve individual survivors, families, and children who are impacted by DV.

There are a number of key steps that State Mental Health and Substance Use Disorder Treatment Directors can take to support individuals and families affected by DV and that State FVPSA Administrators can take to support survivors and children experiencing the traumatic mental health and substance use effects of DV. We encourage state mental health, substance use disorder, and DV agencies to form partnerships at the state level and to create opportunities for cross-sector partnerships at the local program and community level, including cross-sector training, communication, and referral.

---

[37] Warshaw, C., Brashler P. Mental Health Treatment for Survivors of Domestic Violence. In C. Mitchell and D. Anglin (Eds.), *Intimate partner violence: A health based perspective.* New York: Oxford University Press (2009)

[38] Durborow N., Warshaw C., Lyon E. Multi-Site Initiative Report: Building Capacity to Support Survivors Who Experience Trauma-Related Mental Health and Substance Abuse Needs. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. 2013.

Ultimately, optimally serving individuals, children, and families affected by DV requires services that incorporate the expertise of the mental health, substance use disorder, and DV fields while attending to the unique issues faced by DV survivors and their children. We believe that we will all be better equipped to meet the needs of DV survivors and their children if we work together.

STRATEGIES THAT STATE MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT DIRECTORS COULD IMPLEMENT IN THEIR STATES:

1) **Encouraging mental health and substance use providers to receive training on identifying and responding effectively to DV in their work.** There are a number of excellent resources available to assist in these endeavors (see Resources, below).

2) **Developing strategies for incorporating responses to DV into state and local policy and practice to safely link individuals and families to DV services.** This could include encouraging all mental health and substance use disorder treatment programs to have protocols and linkages in place to effectively respond to clients who disclose DV or are facing an emergency situation involving DV.

3) **Promoting whole-family treatment approaches** that support the child-parent bond in mental health and substance use disorder treatment settings. There are a number of evidence-based trauma treatment modalities for children exposed to DV that focus on supporting children's attachment to the non-abusive parent and that support the primary caregiver's skills as a parent. Where possible, providing whole-family treatment in outpatient and residential treatment service settings along with DV advocacy services/resources can strengthen the child-parent bond and address practical and safety concerns.

4) **Developing partnerships with State FVPSA Administrators and state, territorial, and tribal DV coalitions.** Each state and territory has a state FVPSA Administrator and a HHS-designated Domestic Violence Coalition. In addition, many states also have Native American Tribes and tribal coalitions that provide FVPSA-funded DV services. Working together and sharing information about ongoing initiatives can help identify opportunities for building collaborations between DV and mental health/substance use disorder services, opportunities for training, and other strategies for addresses the complex needs of this population.

STRATEGIES THAT STATE FVPSA ADMINISTRATORS COULD IMPLEMENT IN THEIR STATES:

1) **Ensuring your state's DV programs are designed to serve all victims of DV and their families, including those with mental health or substance use disorder needs, without unnecessary barriers.** FVPSA-funded DV programs are prohibited from using inappropriate screening mechanisms for entrance to shelter including mental health or substance use disorder screening tools, and must not require clients to participate in services (including mental health counseling or substance use disorder treatment) as a condition of

receiving shelter or other supportive services. (FVPSA regulations are available at https://www.gpo.gov/fdsys/pkg/FR-2016-11-02/pdf/2016-26063.pdf)

2) **Encouraging training on mental health, substance use, and trauma-informed best practices for staff at DV programs.** Learn more about mental health and substance use disorder prevention and treatment resources, particularly resources that are gender-responsive, culturally appropriate, and trauma-informed.

3) **Fostering collaboration between DV and mental health/substance use service providers in your state.** Encourage all DV programs to have protocols and resources in place to effectively respond to clients who disclose needs related to mental health or substance use or are facing a related emergency situation. This could include developing state level partnerships with State Mental Health and Substance Use Disorder Treatment Directors as well as supporting local DV programs in building partnerships with mental health and substance use disorder service providers and responding effectively with trauma-informed strategies.

RESOURCES

National resource centers and technical assistance

- The National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) provides training, technical assistance and consultation on the intersection of DV, trauma, substance use disorder and mental health including strategies for providing mental health and substance use disorder treatment in the context of DV.
  For more information about individualized technical assistance, call 312-726-7020 or at http://www.nationalcenterdvtraumamh.org/contact-the-center/.
  For NCDVTMH resources specifically for mental health and substance use disorder providers, please visit: http://www.nationalcenterdvtraumamh.org/trainingta/resources-for-mental-health-substance-abuse-treatment-providers/.

- The National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) offers consultation and technical assistance, education and outreach, and resources to support a broad range of service systems, including systems providing mental health and substance use disorder services, housing and homelessness services, HIV services, peer and family organizations, child welfare, criminal justice, and education. https://www.samhsa.gov/nctic/about

- The National Association of State Mental Health Program Directors (NASMHPD) works with states, federal partners, and stakeholders to promote wellness, recovery, and resiliency for individuals with mental health conditions or co-occurring mental health and substance related disorders across all ages and cultural groups, including: youth, older persons, veterans and their families, and people under the jurisdiction of the court. www.nasmhpd.org

- The National Domestic Violence Hotlines provide free and confidential help victims of DV 24 hours a day in over 200 languages. The following hotlines can help victims of DV and sexual violence find support and assistance in their communities:
    - National Domestic Violence Hotline: 1-800-799-7233; TTY 1-800-787-3224. http://www.thehotline.org
    - National Dating Abuse Helpline: 1-866-331-9474 http://www.loveisrespect.org
    - National Sexual Assault Hotline (RAINN): 1-800-656-4673 https://www.rainn.org

- State Mental Health Directors and State Substance Abuse Directors can request technical assistance on this topic through the SAMHSA TA Tracker. http://tatracker.treatment.org/login.aspx

- For a listing of state and territory DV coalitions see: https://nnedv.org/content/state-u-s-territory-coalitions.

- For a listing of tribal DV coalitions see the National Indigenous Women's Resource Center (NIWRC): http://www.niwrc.org/tribal-coalitions as well as many other resources related to violence against Native women.

Resources on children exposed to DV

- The National Child Traumatic Stress Network (NCTSN) provides a wealth of resources on child trauma treatment including information specifically on children exposed to DV: http://www.nctsn.org/trauma-types/domestic-violence

- Promising Futures Without Violence is an online resource center of best practices for serving children, youth, and parents experiencing DV. http://promising.futureswithoutviolence.org

Online learning and toolkits

- Domestic Violence: Understanding the Basics is an hour-long online eLearning module developed by the National Resource Center on Domestic Violence and VAWnet. http://vawnet.org/material/domestic-violence-understanding-basics

- Health Cares About Domestic Violence provides tools and resources for responding to DV in healthcare settings: http://www.healthcaresaboutipv.org

- The SAMHSA-HRSA Center for Integrated Health Solutions provides resources on trauma and screening: http://www.integration.samhsa.gov/clinical-practice/trauma#screening%20tools

- The National Center on Domestic Violence, Trauma & Mental Health offers several resources on collaborative efforts among the DV and mental health and substance use disorder fields: http://www.nationalcenterdvtraumamh.org/wp-

content/uploads/2014/09/NCDVTMH-Multi-Site-ReportRWDedits9.16CW9.17.14-rwd-final.pdf and https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.5.230

INQUIRIES

Please direct any questions on this Information Memorandum to:

Valerie Kolick
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 18E01D
Rockville, MD 20857
Valerie.Kolick@samhsa.hhs.govwww.samhsa.gov

Shawndell DawsonDirector, Division of Family Violence Prevention and Services
Family and Youth Services Bureau
Administration on Children, Youth and Families
Administration for Children and Families
U.S. Department of Health and Human Services
shawndell.dawson@acf.hhs.gov www.acf.hhs.gov/fvpsa

Lynn A. Johnson

Lynn A. Johnson
Assistant Secretary, ACF

JAN 15 2019

Date

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use

JAN 18 2019

Date