North Dakota Domestic & Sexual Violence Coalition

Wise Action CONSULTING

Bridges Over Barriers

A Needs Assessment on North Dakota's Response to Survivors of Domestic Violence with Co-Occurring Behavioral Health Issues

September 2025

Executive Summary

North Dakota Domestic and Sexual Violence Coalition (NDDSVC) commissioned this Family Violence Prevention and Services Act (FVPSA) Grant Needs Assessment Annual Update project to examine how survivors of domestic violence with co- occurring behavioral health issues are supported across North Dakota. Survivors and advocates alike report that the prevalence and severity of these intersecting issues are increasing, yet the state's current service and response systems remain insufficient to meet the complexity of survivors' needs. The project sought to document survivors' lived experiences, identify strengths and gaps in service delivery, and develop recommendations for strengthening responses at the individual, community, and systems levels.

Over a ten-month period, this Needs Assessment project engaged thirty survivors across the state as well as advocates from over 80% of North Dakota's domestic violence advocacy programs, behavioral health and treatment providers, and a multidisciplinary group of responders. Survivors described experiencing profound forms of abusive coercive control tactics, isolation, and repeated abuse often compounded by substance use as a coping strategy, untreated complex trauma, and abuser-driven behavioral health manipulation. Nearly all participants reported significant mental health complications, more than half disclosed substance abuse challenges, and more than one-quarter reported a diagnosed mental illness. Advocates in every region of North Dakota confirmed that survivors presenting with these complex needs represent a substantial and growing portion of their caseload.

The Needs Assessment findings highlight persistent barriers to survivor safety and recovery. Survivors reported long wait times and prohibitive costs for substance use/abuse or mental health/mental illness treatment, a lack of integrated and culturally competent services, and limited access to transportation, childcare, or family-centered support. Domestic violence advocacy programs, while often serving as lifelines, noted their own limitations in responding to severe behavioral health needs. Advocates described workforce shortages, turnover, and the absence of wrap-around services as major constraints, leaving survivors without sustained care. Participants also underscored the strain of navigating multiple, fragmented systems, where accountability for abusers is inconsistent and survivors are too often misidentified, dismissed, or criminalized.

In the midst of these identified challenges, promising practices were also noted. Survivors valued low-barrier entry into services, trauma-informed and culturally specific advocacy, and flexible peer-support models that reduced isolation and built trust. Tangible supports such as housing assistance, replacement phones, and advocacy during court or medical processes were cited as crucial to safety and stability. Effective interagency collaboration, "warm handoffs" between providers, and trusted personal referrals stood out as essential practices that reduce barriers and foster continuity of care.

Based on the Needs Assessment findings, this report recommends action in four priority areas: 1) improving the identification of domestic violence within substance use/abuse treatment and mental health services; 2) increasing accountability for offenders using coercive control by

differentiating resistive violence from other forms of domestic violence and by addressing persistent family court issues; and 3) expanding flexible and gender-specific peer support options; and 4) enhancing guidance and tools for local domestic violence advocacy programs working with survivors with co-occurring behavioral health issues. Together, these strategies aim to build a more integrated, survivor-centered response that acknowledges the complexity of trauma, strengthens protective networks, and increases accountability for those who use violence.

This report underscores that survivors with co-occurring substance use/abuse issues, mental health challenges, and/or serious mental illness/mental health disability are not outliers but a significant portion of those seeking help in North Dakota. Their voices reveal both the barriers that perpetuate harm and the pathways that support resilience and recovery. By investing in systemic change, strengthening coordinated community responses, and centering survivor safety, North Dakota can move toward a more effective, equitable, and life-saving response for survivors and their families.

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Background

North Dakota Domestic and Sexual Violence Coalition (NDDSVC) works to support and present a unified voice for the 18 service provider programs across the state. NDDSVC focuses on connecting victims of sexual and domestic violence as well as dating violence, stalking, and human trafficking to services in their communities. NDDSVC also connects diverse partners in communities across the state to better serve victims, from social and legal services to law enforcement and legislators.

NDDSVC commissioned this Family Violence Prevention and Services Act (FVPSA) Grant Needs Assessment Annual Update project to better understand what is working and not working in the current response to domestic violence survivors within the state.[1] Past needs assessments[2] revealed that many victim service provider programs have noticed a growing trend: the survivors they see are experiencing more extreme forms of violence leading to more complex trauma-related behavioral health response needs. This assessment was designed to learn more about the needs of these North Dakotans as they seek help for the abuse they are subjected to by their partners or family members. More specifically, NDDSVC requested a focus on survivors who experience substance use/abuse, mental health, and/or mental illness/mental health disability issues in relation to the domestic violence victimization to which they are subjected.

North Dakota is considered a largely rural state with a few urban centers. With a population of 796,568,[3] over two-thirds of North Dakota counties are designated "frontier" (fewer than 6 people per square mile). In 2024, the state's domestic violence programs served 6,334 victims[4]—a 3.3% increase that is three times the state's population growth. With all but four of the state's 53 counties designated mental health professional shortage areas, survivors face profound challenges in accessing care and support.

Although North Dakota has significantly invested in improving access to behavioral health services, including a substance use disorder (SUD) voucher program to increase access to treatment, demand continues to outstrip supply. Practitioners and survivors have both reported a critical need for more services, particularly those capable of addressing the intersecting nature of domestic violence and victimization-related complex trauma.

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[1] Such needs assessments are required by the Family Violence Prevention and Services Act, 17 U.S.C § 10411(d)(1), (1984) which funds shelter and direct services for survivors of domestic violence, dating violence, and family violence. This assessment is addressing that requirement.

[2] See *Many Voices ND: A Needs Assessment on North Dakota's Response to Domestic Violence* (September 2023) and the *FVPSA Needs Assessment Annual Update Report - 2024* (September 2024) which focused on underserved survivors–specifically Indigenous women in North Dakota who face systemic discrimination within the same areas of need identified in the Many Voices ND needs assessment.

[3] According to the North Dakota Governor's Office citing a July 2024 U.S. Census Bureau estimate.

[4] Based on statistical data collected by the North Dakota Domestic and Sexual Violence Coalition (NDDSVC).

Project Design and Implementation

Methods & Participants

This Needs Assessment Annual Update project used a mixed methods approach to gather information about survivors' needs and experiences. Listening sessions–both focus group and individual–were conducted with survivors, domestic violence advocacy agency staff, behavioral health service providers, and a mixed group of response agency personnel in a coordinated community response training. A Needs Assessment planning committee met in December and January to establish the design parameters, including the specific focus on experiences related to survivors of complex trauma with substantial behavioral health needs. The needs assessment activities ran for ten months--from December 2024 through September 2025.

Survivors

Outreach to survivors to participate in this project were made through NDDSVC member victim service provider programs and through Community Action Partnership local programs[5] in Fargo, Devil's Lake, Dickinson and Williston. Survivors were offered gift cards as compensation for their time in interviews and focus groups. Their childcare and transportation costs were also reimbursed partially or in full as needed. Two of the focus groups were held with women in an in-patient substance abuse treatment program. In total, 30 survivors provided information through six focus groups and at least four individual interviews. A description of the survivors who participated in the needs assessment can be found in Appendix B.

Victim Service Providers

Front-line victim service provider program staff and program directors from over 80% of the domestic violence services agencies across North Dakota were consulted through meetings between February and August 2025. Over 36 program staff from 16 programs shared their thoughts and beliefs in one or more of the eight meetings where the project was discussed.

NDDSVC staff were also consulted through a combination of individual interviews and a group discussion at an in-person meeting in August 2025.

Behavioral Health Service Providers

Six professionals working in or with behavioral health (representing public health, human services, law enforcement, substance abuse treatment, and mental health therapy) were also interviewed.

[5] NDDSVC partnered with Community Action Partnership of North Dakota (NDCAP) to identify local CAP programs willing and able to conduct outreach to invite survivors to focus group sessions. Due to significant funding shifts facing CAP programs during the project period, project leaders focused on engaging CAP programs where an anchor domestic violence program was identified to provide additional support and collaboration. Thanks to the efforts of these CAP staff, the outreach did lead to additional survivors' participation in a few locations. Without their efforts, these voices may not have been heard.

Multidisciplinary Responders

A mixed group of 23 responders (law enforcement, advocates, 911 responders, and prosecutors) also provided insights on related questions to capture broader system responses at a June 2025 NDDSVC training on strengthening the coordinated community response to domestic violence.

Defining Substance Abuse, Mental Health, and Mental Illness

Working definitions of the three co-occurring behavioral health issues were employed in the Needs Assessment project as follows:

Substance abuse–a destructive pattern of using drugs or alcohol (ETOH) which leads to impairment or distress and continuing despite it causing significant problems for the user.[6]

Mental health–the management of one's emotional, psychological, and social well-being. "Mental health issues" in this context relate to challenges managing stress, emotions, coping, social interactions and relationships, and not feeling a sense of well-being.[7]

Mental illness– a mental, behavioral, or emotional disorder that, left untreated, causes frequent stress and affects a person's ability to function in their daily life. These include brain disorders that may also appear as physical problems. Typically, mental illness is diagnosed and treated with a combination of medication and psychotherapy.[8]

Since these issues in the lives of survivors are often related to significant and/or long-term traumatic victimization experiences, we occasionally use the term "complex behavioral health issues" as an umbrella term for the discussion of our findings and recommendations.

Findings

NDDSVC's 2022-2023 Needs Assessment report, *Many Voices ND*, identified five core areas of high need for survivors; 1) safe and affordable housing, 2) transportation, 3) access to appropriate mental health care, 4) economic security for themselves and their children, 4) legal assistance, and 5) advocacy.[9] These themes persisted in this current assessment, confirming their status as critical and ongoing challenges. Our study specifically explored the third theme–access to mental health care–by centering the experiences and needs of survivors with complex needs and the accounts of the professionals in their support network.

Nature and Prevalence of Co-Occurring Behavioral Health Issues

Literature

[6] Modified from definitions developed by APA & ASAM adapted by DV/SA Task Force of IL DHS, 7/2000 as presented by Patricia Bland, M.A. CCDC, in *Getting Safe and Sober: Real Tools You Can Use*, undated, slide 89.
[7] Adapted from the Centers for Disease Control (CDC) definition.
[8] Adapted from the National Alliance on Mental Illness (NAMI) definition.
[9] *Many Voices ND: A Needs Assessment on North Dakota's Response to Domestic Violence*, page 4

Numerous studies have highlighted the prevalence of traumatic victimization and co-occurring behavioral health disorders among survivors. In a study done at multiple substance treatment centers across the United States, most women reported experiencing one or more forms of abuse including physical abuse or neglect, sexual abuse, and/or emotional abuse or neglect with rates ranging from 32% (for physical neglect) to 91.5% (for physical abuse). Almost three-quarters, or 74%, experienced multiple and repeated forms of abuse.[10]

In another study, 59% of psychiatrists across the UK identified violence and abuse as one of the top three issues contributing to poor female mental health–more than cited money worries, loneliness, hormonal health or work/exam pressures.[11] A meta-analysis completed over five years found that past physical or sexual abuse is reported by 50–70% of women psychiatric inpatients, ~70% of women seen in ERs, and 40–60% of women psychiatric outpatients. Of women receiving treatment for substance-use, 55--99% report being victimized at some point in their lives.[12]

Perpetrators often induce substance use or attack a victim's mental health as a means of enforcing coercive control over their partners leading to significant challenges for survivors. While the relationship between these co-occurring factors is multi-faceted, these studies demonstrate the significant connection between complex behavioral health issues and violence.

Domestic Violence Service Providers' Sense of Behavioral Health Issues Prevalence Among Survivors

North Dakota local program advocacy and shelter staff report that a substantial number of the domestic violence clients they serve face significant mental health, mental illness or substance use/abuse challenges,[13] with the prevalence they see varying by region. From their perspective, the most common co-occurring issue among the survivors they serve is general mental health issues which are described as significant enough to interfere with a survivor's ability to help themselves or their children. Some programs indicated near-universal prevalence of mental health issues among the survivors they serve. Next most common among domestic violence victims are substance abuse issues, followed by mental illness. One or more program staff reported that up to half of their clients face challenges with mental health or mental illness in each of five regional human service regions. Despite limitations which make more precise interpretations possible,[14] only a handful (5 of 26) of these advocates/shelter staff estimated that fewer than 10% of their clients experienced one of

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[10] Marion A. Becker et al., "Characteristics of Women Engaged in Treatment for Trauma and Co-Occurring Disorders: Findings from a National Multisite Study," Journal of Community Psychology 33, no. 4 (2005): 439.

[11] As cited in "Abuse is a main driver of mental ill health in women and girls, say psychiatrists" by Denis Campbell in the Guardian, 8 March 2024.

[12] Dawn J. Moses et al., "Creating Trauma Services for Women with Co-Occurring Disorders," Women, Co-Occurring Disorders & Violence Study (2003): 5.

[13] Summary of feedback from live polling conducted with advocates and program directors in three NDDSVC meetings held in February and March 2025: Membership Meeting (2/10/25), Domestic and Sexual Violence Advocacy Network (2-12-25), and Shelter Network Committee (3/12/25).

[14] There were several limitations with the polling which make it difficult to further interpret the data. For example, the range in responses could be due to differing perceptions by advocates within the same program, or by different advocacy programs serving communities across the same human services regional office areas.

these co-occurring issues.[15] This data confirms that advocacy programs are working with many North Dakotans with complex behavioral health needs. Calculating off of their reported service numbers, that could be anywhere from 600 to several thousand domestic violence survivors in a given year.

Nature of Survivors' Experiences with Behavioral Health Issues

Survivors experiencing significant mental health, mental illness or substance use/abuse issues were recruited for this project's listening sessions. Participating survivors self-identified (when they chose to) which of the three co-occurring issues they were experiencing. Based on survivors' own disclosures, approximately 63% had substance use/abuse issues, at least 90% had mental health complications (three did not disclose or it was unclear from their disclosure), and approximately 27% had or were dealing with mental illness.

These survivors described domestic violence victimization that included verbal, physical, and sexual abuse with details in each category of abuser tactics presented on the Power and Control Wheel. Particularly salient for these survivors in relation to the co-occurring issues they experienced were emotional manipulation through gaslighting and retaliation (e.g. using jealousy, untruthful accusations, etc.), entitlement and lack of accountability for their abusers, substance use and abuse as a tactic of the abuser or in response to managing the impact of the abuse,[16] and severe and/or long-standing abuse.

> *He had it in his head that I must have cheated on him, and so he grabbed my son's hair, held a knife up to him, and he said, 'Just tell me. Just tell me who it is. –Survivor*

> *He was born and raised here. And, you know, so we moved up here, and then, of course, everything just, you know...I had no access to the outside world, lived in a tiny apartment, wasn't allowed to leave the apartment, wasn't allowed to talk to anybody, and I was scared to death. When he'd come home, he said," You talk to anybody today?" and I'm certainly not going to talk to you, because I'm not going to lie. So, I was isolated. I wasn't allowed to talk to my family. - Survivor*

> *I called the police so many times, and they never did anything. They would just tell him to leave for the night, and then he'd come back the next day. Nothing ever happened to him. - Survivor*

> *My ex-husband wasn't physically or sexually abusive, but very emotionally and verbally abusive. It was so bad I ended up coming down with panic attacks and depression—diagnosed by a psychiatrist. I didn't tell the doctor at the time [of his abuse] because I didn't see the connection. -Survivor*

[15] Even in the service area in which one of these program staff estimated the prevalence for all three issues at "less than 10%" of their client populations, three other program staff in the same service area indicated consistently higher estimates.

[16] Nearly all the survivors in listening sessions conducted in the in-patient substance abuse treatment setting described how their substance abuse was tied to the domestic violence and/or trafficking to which they were subjected.

My ex-husband started me on meth. -Survivor

Responding Systems and Agencies–Survivor, Advocacy Program Staff, and Practitioner Experiences

The following sections address what domestic violence survivors, advocates, and behavioral health/substance abuse treatment practitioners said about the challenges both survivors and responding agencies face in addressing these survivors' needs, the domestic abuse itself, and what could strengthen responses.

Survivors' Experiences with Shelters, Advocacy and Treatment Services

Interviewees provided examples of practices, programs, and approaches that are working for domestic violence survivors with co-occurring behavioral health issues. Helpful responses they described include:

- Low-barrier access (when survivors can access treatment services even when they are actively using substances).
- Peer and open-ended support groups.
- Flexible access (including walk-in evaluations).
- Financial support and state-funded vouchers.
- Effective staff training (on trauma-informed care, cultural competence, etc.).
- Culturally competent services, especially Indigenous-led services.
- Collaboration and coordination between agencies and providers.
- Meeting basic needs first (e.g. housing, food, safety).
- Non-judgmental support and privacy protections by staff (e.g. building trust by meeting survivors where they are).
- Providing warm handoffs and personal referrals (e.g. accompanying survivors to appointments, personally introducing them to new providers) including those for human trafficking survivors.
- Virtual support groups and possibly telehealth options (e.g. some Regional Human Service Centers are piloting Avel telehealth to increase access for people needing services).

The [staff at advocacy agency] are awesome ..... They only do what you share with them; they could only help you so far. So, if you're struggling with something, and you tell them, they will do their best ability (sic) to help you. -Survivor

They do art therapy group once a week for [the kids]. -Survivor

I think that's a really awesome thing about having advocates that can be there to

> *do that, that warm transfer. 'Hey, you know what? I know somebody over at that agency. Let me give them a call. I will talk to them on speaker phone or even go there with them in person." You know what I mean, because it can be very, very overwhelming. - Survivor*
>
> *One of the first shelters I ever went to, that I don't see in the shelter [in this city], is [support gatherings] on a daily and weekly basis…[and] provided childcare. And it's refreshing to know, first, you're not alone. And secondly, your children, kind of bond a little bit... it was nice. It was different than therapy, which I personally have been fighting for so long. I like group therapy, but I don't like one-on-one. [I] feel like, if I unpack it, it's never gonna go back in.- Survivor*

Survivors also specifically cited that tangible help--such as a replacement phone when the abuser takes their phone or advocacy help getting out of a lease so they wouldn't face eviction--makes a big difference to them.

Challenges

While several interviewees noted that North Dakota's increased funding for substance abuse treatment had made a meaningful difference,[17] challenges of finding and accessing needed care still remain. Challenges interviewees described include:

- Long wait times and limited availability for substance abuse and mental health services.
- Transportation challenges such as long distances to travel, cost, and a lack of public transportation options.
- Lack of integrated care options (where survivors can receive services that address domestic violence, mental health, and substance abuse).
- Lack of culturally competent and language-accessible services.
- Stigma and judgment.
- Costs of care--some survivors don't have insurance and are having to choose between paying for treatment and other basic needs like housing or food.
- A shortage of qualified providers across the state and in many service/response areas--particularly mental health professionals, substance use counselors, advocates, and pro bono attorneys.
- Lack of childcare and family-friendly services.
- Barriers in bureaucratic service systems--such as extensive paperwork and eligibility requirements (requiring sobriety or a diagnosis) that don't fit well with survivors' situations.

[17] Specifically mentioned was greater funding and access North Dakota had allocated to substance abuse treatment during the administration of Governor Burgum. In particular, voucher programs were mentioned as being particularly useful and that additional funding had allowed for the addition of walk-in screening hours for some treatment providers.

Even when survivors can access services, many note that the intensive nature of the therapy and exhaustion that comes with addressing the trauma is “like its own full-time job”:

> *When I first started seeing [my therapist], I would schedule my appointments for three o'clock. So then at four, I was like, Oh, I just gotta go home now. It was exhausting addressing trauma, but not only past trauma, but like [the abuse] continued. -Survivor*

And that the lack of accountability or intervention for the perpetrator led to additional trauma, more work, and exhaustion:

> *It was almost like we every single time I would do one part of my trauma work, it just got set back, and then I do that again, and we got set back. And we just, like, kept restarting it, and that it was so exhausting. - Survivor*

Survivors also described the time and energy it takes for them to learn all new processes in order to benefit from the services that do exist:

> *And then how much energy and time and all that... because they, they talk about how they're trained to be advocates, but we're not trained to be victims, like we don't know what we're supposed to do. - Survivor*

Both survivors and advocates interviewed also identified specific challenges they see in domestic violence shelter settings as well as other housing services such as sober living facilities or homeless shelters. Challenges cited include the lack of timely access to shelters and appropriate mental health services for their children, lack of peer and drop-in support groups, lack of culturally competent services and long-term support resources, and safety concerns associated with residents’ substance use.

> *It’s so hard to even just get into a shelter, because they’re always so packed. Especially in the wintertime. I mean, it took me four months just to get in. -Survivor*

> *Of course, the other thing that we do really need is…better resources for helping our kids. Because a lot of times they say you can’t go into any type of therapy until they’re three. And then once you get to three, you think they’re a little bit better, but you’re not sure. But obviously they’re not. - Survivor*

> *It has to be more long term. It can't be short. Because that's why these women go back to these abusive relationships, is because they don't have enough resources to stay out of it. - Survivor*

Treatment providers also noted that some housing settings are not available to those on medication:

> *Depending on the sober living [housing], they’re not going to be accepted if they’re prescribed medication assisted treatment... Our folks are getting excluded because of the medications that they’re being prescribed. Never mind that there’s evidence and*

extensive research to support the efficacy of the medications. They are being excluded for the pathway they have chosen for their recovery. –Treatment provider

Challenges Cited by Advocates, Including Perceptions of North Dakota's Regional Human Services Center Model

Domestic violence advocates interviewed also identified the challenges with services access noted above and added their own challenges including capacity and resources "especially with workforce shortages and turnover," client needs for psychiatric or mental health care that go beyond their capacity and primary purpose, and "a feeling the community perceives that because they are a shelter provider they should accept anyone in need of housing."

Survivors accessing domestic violence shelters and advocacy programs in North Dakota frequently present with co-occurring substance abuse and mental health challenges that go beyond what traditional advocacy services are designed to handle.[18] These programs see their role as experts in domestic violence advocacy, survivor support, and safety planning, not as the primary providers for survivors' complex behavioral health needs. They describe those other services as "wrap-around" supports. In general, they do not believe there are enough of them—and the services that do exist are often a significant distance away from where survivors live and work.[19]

Advocates' Perceptions of the Regional Human Service Centers

Domestic violence service providers have varying opinions of the preparedness level of North Dakota's Regional Human Service Centers in their service areas to work with domestic violence survivors experiencing behavioral health challenges. In informal polling in February and March 2025, domestic violence program staff were asked to rate seven attributes of the services offered by the primary Center with which they work. Attributes assessed were: 1) access to needed services regardless of ability to pay; 2) rapid triaging for anyone with acute or severe symptoms; 3) making useful referrals for needed services; 4) making referrals for your agency's services for any domestic violence survivor; 5) access to the right kind of care provider for the survivors' needs; 6) respectful and fair treatment for all patients; 7) facilitative to assist with access to carrying out care plan-transportation, medication, etc. The polling scale was 0: "Poorly or Highly Inconsistent" to 10: "Great and Consistently So." Seven regional human service centers received ratings.

Four different Regional Human Service Centers received a score of 10 on one or more of the three following attributes: "access to needed services regardless of ability to pay," "rapid triaging for anyone with acute or severe symptoms," and/or "respectful and fair treatment for all patients." One Center also received a score of 10 for "making useful referrals for needed services" and "facilitative to assist with access to carrying out care plan-transportation, medication, etc.". However, "making referrals for your agency's services for any domestic violence survivor," and "access to the right kind of care provider for the survivors' needs," were

[18] Summary of feedback from live polling conducted with advocates and program directors in three NDDSVC meetings held in February and March 2025: Membership Meeting (2/10/25), Domestic and Sexual Violence Advocacy Network (2-12-25), and Shelter Network Committee (3/12/25).
[19] Ibid.

rated very low for that same region.

When *average* scores were calculated (when more than 1 provider voted) for each attribute, 88% of these scores were below a rating of 5. Three regional Centers did score averages between 5 and 6 for one or two of the following aspects: “rapid triaging for anyone with acute or severe symptoms,” “respectful and fair treatment for all patients,” and “access to the right kind of care provider for the survivors’ needs.” There were important limitations with the poll, including the unequal voting for each service area (ranging from 0 to 4 advocates responding to each aspect) and the lack of context to understand the extent and nature of each advocate’s exposure to the Regional Human Service Center in their area (e.g. interacted directly with staff, heard from survivors or other advocates, etc.). Nonetheless, the poll does provide a glimpse into advocates’ perception of accessibility, coordination, and client care of the Regional Human Service Centers’ behavioral health services available in their region.

Domestic violence program staff note that the lack of sufficient (accessible, quality) services puts stress on advocates who have varying degrees of experience responding to significant mental health or substance abuse issues. This can lead to difficult choices on how to give survivors the attention they need—and can lead to overall staff burnout.

> *That takes all of our time…. we’re already short staffed because budgets are tight. When you have a house full of 15 women and eight children and…13 of them right now have complex mental illness, whatever, but now you just had those two incidents. Yeah, that takes up all your staff right there, and then everybody else is neglected, yeah, and then they go through crisis too, which it's like you're just constantly trying to put out the fire to survive. - Advocate*

> *I felt really bad for [my staff member], especially because she had worked for three years to build [the survivor’s] trust. And then [the survivor] turned on [my staff member] and yeah, which is very common with mental health, but it's just hard. It's heartbreaking. You want people to get better, and you want to be one of the steps in their journey, and sometimes you can't. -Advocate*

Even with four advocacy programs in the state who offer counseling services with on-site therapists, some survivors need far more specialized care than these services are designed to provide.

> *I asked our therapist if we could refer [the survivor] to the state hospital. She's like, “well, good luck.” [The therapist] was telling me about some of the things she tried to refer, like, where someone literally cut, like another staff member with a knife, and they couldn't get them in….There's no middle level. It's just, it's either they're a danger to society or they're a candidate for shelter, and they get better. - Advocate*

> *I just remember feeling so helpless, and knowing that, like, if she didn't get that elevated level of care, it wouldn't be good for her, or our community, or our people. It was just like, just feeling so helpless. -Advocate*

Survivors' Experiences with Other Response and Support Systems

Domestic violence survivors described some benefits and many challenges they had with criminal and civil legal systems (i.e. police, legal aid, victim services and courts), government and human services (i.e. child protection, county social services, supervised visitation centers, foster care system), medical services (i.e. ER, doctors, tribal health), and public and private mental health services (i.e. crisis teams, therapists, counselors) in their areas of the state.

Experiences survivors reported with the ***criminal and civil legal systems*** included:

- Law enforcement not referring survivors to advocacy and support services, believing abusers over victims because the abuser knew the officers and was charismatic, failing to intervene with on-going abuser threats, not properly interviewing survivors when neighbors called, and dismissive or hostile treatment of victims.
- Being too afraid to call the police, fearful of what an abuser would to do to her after the police left.
- Direct threats to survivors from abusers in the courtroom and threats not being taken seriously until court personnel themselves were threatened.
- Having mental health or mental health treatment used against them in child custody cases.
- Inability to access legal aid due to shortages of attorneys, lack of transportation, or limited phone access.
- Courts not issuing protective orders or issuing insufficient sentences to abusers for the violence they perpetrated.
- No prosecutor informative/supportive services offered to the survivor who had to come from out of town to testify in the case.
- Misidentification as the abuser when the survivor uses resistive violence.

Two survivor accounts did indicate positive and thoughtful law enforcement responses. In these instances, survivor's shared that they felt they were "taken seriously," were not blamed for the abuse, and ultimately the abuser was arrested.

Experiences survivors reported with ***government and human services*** included:

- Denial of assistance because the abuser's income was counted even though he was not providing for her or her child.
- Counselors allowing an abuser to remain present with the survivor during her sessions,

believing the survivor was "not stable enough," and letting the abuser speak for her.

Experiences survivors reported with ***medical services*** included:

- Being blamed, dismissed, or treated rudely because of what they perceive as staff bias against substance users and/or Indigenous women.
- Neglecting to screen or identify the domestic abuse and potential injuries—including during treatment for anxiety.
- Failure to separate the patient-survivor from the abuser to allow for disclosure.
- Inadequate attention to/or resources for a survivor's son who was displaying severe mental health issues.

Two encouraging experiences were noted; a survivor who was treated well by medical responders when she received a medical exam, and a hospital with a sign in the bathroom offering discreet ways for survivors to signal staff if they need help.

Experiences survivors reported with ***mental health services*** included:

- Therapists being intimidated by threats from the abuser leading to lack of care for the survivor.
- Therapists being subjected to false reports by abusers to interfere with care for survivors and their children.
- Crisis response "taking a long time."
- Survivors being concerned about the misuse of anger management or couple's therapy for abusers.

These findings show that survivors with complex mental health needs and substance abuse issues experience both critical support and barriers in their efforts to find safety and well-being. Since their behavioral health challenges are significantly tied to the experience of abuse, when intervention opportunities are missed and accountability for offenders is lacking, the barriers to achieving stability and wellbeing increase for survivors and their children. Advocates across North Dakota consistently describe their role as both indispensable and constrained—offering life-saving support to survivors while simultaneously navigating the limitations of under-resourced systems. Their insights underscore how gaps in the current response impact their work as well. The practices described which survivors and advocates do find effective bridge barriers faced by too many survivors. The following section provides key recommendations to build more bridges.

Recommendations

Recommendation 1: Improve Identification of Domestic Violence by Substance Abuse Treatment Providers and Mental Health Specialists

Substance use treatment providers and mental health specialists need to improve and enhance their assessments, screening, and understanding of domestic violence and the power dynamics that victim-survivors experience.

Two specific recommendations focus on connecting survivors to the help they need by improving how treatment providers assess for domestic violence:

1. Develop a collaborative project between leading treatment specialists and NDDSVC and member programs to improve screening and referral tools.
2. Address the safety risks faced by survivors when help-seeking for mental health or substance use disorders.

As noted above, there is a high rate of co-occurrence between substance use and/or mental health challenges and domestic violence. Of the thirty survivors interviewed, 63% had substance abuse issues and nearly all stated that their substance use disorder was directly tied to the abuse they experienced. Substance use and mental health providers should not presume that because a client does not bring up the domestic violence that it is not a core underlying issue. A leader in the substance use field in North Dakota stated, “A lot of the women we see, their substance use is directly tied to the abuse they’ve experienced, but the treatment centers don’t always ask about that or offer support for it.”

Practitioners described a gap in how survivors receive help--that substance use is seen as the only or most prominent problem and the violence survivors are currently experiencing or experienced in the past is ignored. This in turn increases the safety risks and decreases the safety of survivors. One substance abuse treatment provider stated, “Sometimes the only reason a woman is using is to cope with the abuse, but if no one addresses the abuse, she’s likely to relapse.” To address this, the authors recommend NDDSVC and its member programs coordinate with respected substance and mental health treatment providers to explore ways to address safety risks that survivors face when seeking help for the co-occurring issues they face–both in treatment and post-treatment.

Recommendation 2: Increase Accountability for Offenders Using Coercive Controlling Domestic Violence; Differentiate Resistive Violence; Address Systemic Safety Issues in Family Court

Three specific recommendations focus on increasing accountability for abusers:

1. All responders, and particularly multi-disciplinary/coordinated community response/CCR groups need to elevate attention to accountability for offenders utilizing coercive-controlling violence and abuse.
2. Develop the skills of CCRs to differentiate interventions for those intimate partners who use coercive control versus those who use resistive violence.

3. Assess how family court and/or custody court decisions impact the safety of survivors and their children, and the role these legal proceedings play in exacerbating survivors' mental health and substance use challenges.

Domestic violence offenders need to experience sure and swift consequences and accountability for the violent coercive control tactics that victim- survivors experience, for victim-survivors' complex trauma-based mental health and substance abuse impacts to improve. When a victim-survivor has a known substance use and/or mental health disorder, if an abuser tells a system provider/responder that they do, the attention to the offender's violence wanes and shifts to the victim-survivor's mental health and/or substance use.

Survivors of domestic violence in North Dakota consistently reported that the lack of accountability for offenders—such as minimal legal consequences, repeated dismissals by law enforcement, and failure to mandate treatment—has a profound negative impact on their mental health. This ongoing impunity leads to feelings of helplessness, anxiety, and persistent fear, as survivors are forced to remain hyper-vigilant and often feel unsupported by the systems meant to protect them. Many survivors describe how the absence of meaningful consequences for offenders prolongs their trauma, delays healing, and contributes to depression, hopelessness, and a sense of injustice.

Developing CCRs that include multi-agency accountability measures and/or teams can enhance accountability for offenders of domestic violence. The Blueprint for Safety, developed by Praxis International, provides multi-agency team recommendations for communities to consider. The authors recommend that NDDSVC selects 2-3 communities in North Dakota to pilot to enhance CCR work for accountability.

At the same time, it's essential that CCRs create and implement policies that differentiate between the types of domestic violence (coercive control, resistive, and violence unrelated to coercive control) and address coercive controlling violence specifically. In the course of listening sessions, a number of survivors and practitioners described the need for CCRs to account for the contextual differences between these types of domestic violence.[20] Survivors often engage in resistive violence after prolonged exposure to coercive-controlling violence and abuse, especially when other avenues for protection have failed or when immediate safety is at risk. There is a widespread concern that the justice system does not adequately distinguish between predominant aggressors and survivors acting in resistance or self-defense, resulting in dual arrests or criminal charges against survivors with no self-defense assessment.

That lack of accountability combined with a misunderstanding of resistive violence or a misidentification of the person posing the real threat of future violence leads to the criminalization of survivors who are attempting to protect themselves and/or their children. Many survivors described using force as a last resort after repeated failures of the system to provide safety or accountability for the predominant aggressor. It is our recommendation that the

[20] Includes legal or illegal acts of physical force or resistance by victim-survivors in response to experiencing ongoing coercive-controlling violence and abuse.

Coalition systemically assess the causes of CCRs not accounting for resistive violence in their systemic responses. If the Coalition decides to have 2-3 pilot communities for an enhanced CCR, the focus should include addressing these distinctions.

Both survivors and advocates emphasized that the current family court system in North Dakota often fails to protect survivors and their children and can inadvertently empower abusers to continue exerting control post-separation. There is a strong call for systemic reform, better training, and more survivor-centered practices in custody and family court proceedings.

Recommendation 3: Augment Support for Survivors by Providing Flexible Support Group Options (Including Peer-Support) and Retaining Gender-Specific Support Groups

Two specific recommendations aim to improve support group experiences for survivors:

1. Investigate how to safely offer less-rigid peer support group options to counter the isolation survivors feel.
2. Discuss the benefits and drawbacks of mixed support groups in any setting addressing trauma experiences and address the importance of gender-specific groups.

Coalition and member programs should assess and provide support groups that increase accessibility and are peer-supported while also providing support for support group facilitators.

In a number of interviews with survivors and advocates, there was a concern about the focus and rigidity to services and groups offered that were “trauma-focused” in their titles and descriptions. In addition, there was concern about there not being the flexibility for drop-in support groups. Survivors and advocates discussed the barriers that programs create by requiring intake interviews, a commitment of time and required attendance for a support group. One survivor described it as:

> *Peer support is huge. When you’re in it, you don’t always trust professionals, but you might trust someone who’s been there. And you don’t necessarily want to attend a trauma group because you don’t want to talk about and relive it and that is what I think about when I see that word. But if I knew other women would be there with situations similar to me, I would be more likely to attend. I also need to know that I don’t have to commit to every week because sometimes I just can’t.*

Another survivor stated,

> *I want to go to therapy, okay? But I know that if I go to therapy and I let it out, I'm going to need time and space in order just to maybe stay in bed for a couple of days or cry for, you know, like so I know I need to address it, but who's going to pay the bills in the meantime, right? Who was going to, you know, get my daughter to school, right? How am I not going to get fired? I don't have a job, you know, that's going to give me time off for therapy, for crying out loud, right?*

It was also reported in advocate interviews that local substance abuse providers put men and

women together in substance use disorder groups, domestic violence education groups, and support groups for victimization. There are a number of studies related to trauma and substance abuse providers that favor and recommend that support groups in substance abuse and mental health facilities be provided to survivors according to their gender.[21]

LGBTQ+ individuals or those with non-binary identities may not feel comfortable in binary gendered spaces either—highlighting the need for inclusive and flexible group design. Cultural context, facilitator training and group purpose all significantly affect what structure works best. Because of the cultural context of North Dakota, the input from practitioners and the evidence from the literature, it is our recommendation that the Coalition and/or advocacy agencies address mix gendered substance use disorder groups.[SK1]

Recommendation 4: Enhance Guidance and Supports for Local Domestic Violence Programs on Working with Survivors with the Identified Co-Occurring Issues

Four specific recommendations aim to better address the needs of survivors with substance abuse, mental health issues, and mental illness by 1) better equipping advocates to support survivors with co-occurring issues (e.g. reviewing shelter policies, creating guidance for local programs on working with this population of survivors), and 2) improving the linkages between their services and those of respected and domestic violence-informed therapists and treatment providers (e.g. creating a vetted referral list and a white paper on telehealth for domestic violence survivors).

First, we recommend NDDSVC work with member programs to conduct a comprehensive review of shelter policies across North Dakota to identify and promote trauma-informed procedures that address resident substance use while prioritizing safety, autonomy, and overall well-being.

Additionally, developing comprehensive guidance for local programs on effectively serving survivors with co-occurring issues, including protocols for building and vetting a statewide network of qualified mental health and substance use providers, would support advocates dealing with challenging circumstances especially in the face of burnout and turnover.

The Coalition and advocacy agencies should also consider a project to proactively vet and build relationships with therapists and substance use providers who are grounded in a deep understanding of domestic violence. This prioritizes providers who are not only trauma-informed but also comprehend feminist theory and the power dynamics of coercive control. One critical effort would be the creation of a curated, reliable referral list that ensures survivors are connected to competent, supportive, and safe care.

Finally, to better understand how the promises of telehealth practices can be safe and useful for

[21] Greenfield, S. F., Trucco, E. M., McHugh, R. K., Lincoln, M., & Gallop, R. J. (2007). The Women's Recovery Group Study: a Stage I trial of women-focused group therapy for substance use disorders versus mixed-gender group drug counseling. *Drug and alcohol dependence*, *90*(1), 39–47. https://doi.org/10.1016/j.drugalcdep.2007.02.009; Greenfield, S. F., Cummings, A. M., Kuper, L. E., Wigderson, S. B., & Koro-Ljungberg, M. (2013). A qualitative analysis of women's experiences in single-gender versus mixed-gender substance abuse group therapy. *Substance use & misuse*, *48*(9), 750–760. https://doi.org/10.3109/10826084.2013.787100

survivors, NDDSVC and its members are also encouraged to coordinate with providers to review telehealth pilot projects and create guidance on its recommended use.

Conclusion

This Needs Assessment Annual Update confirms that survivors of domestic violence in North Dakota who are also managing substance use, mental health challenges, or mental illness represent a significant and growing portion of those seeking services. Their stories reflect not only the profound harm of coercive control and repeated victimization but also the compounding weight of stigma, fragmented systems, and limited access to essential supports. These realities underscore that current service structures—though vital—are not sufficient to address the depth and complexity of survivors' experiences.

At the same time, survivors and advocates pointed to practices that do make a difference--caring and nonjudgemental advocacy services, tangible supports like warm handoffs and survivors getting their basic needs met, culturally competent services, and services for their children. These approaches demonstrate that meaningful progress is possible when systems understand the needs of domestic violence survivors, particularly those with complex behavioral health needs.

Ultimately, a key strategy for addressing survivors' behavioral health needs would be to increase the early intervention with and accountability of offenders. Recommendations include ways that coordinated community response teams could collaborate to better identify coercive controlling violence as the form of domestic violence that poses the greatest risk to safety and well-being.

Moving forward, coordination between NDDSVC, domestic violence advocacy programs, behavioral health providers, justice system actors, and state and tribal leaders can support the improvement of assessments, referrals, treatment and support options, and criminal and civil interventions.

By adopting collaborative strategies, piloting enhanced community response models, and creating clear guidance for local programs, North Dakota can begin to close the gaps survivors and advocates have identified and build bridges to safer, better communities for all.

Acknowledgements

The authors would like to express gratitude to the survivors across North Dakota who shared their experiences, insights, and recommendations. Their courage and resilience provide the foundation of this report and inspire more effective and compassionate response services. While guarding your privacy means not sharing your identity, your voices and insights deeply impacted us and formed this report.

The authors also thank the mental and behavioral health providers, domestic violence advocates, and criminal justice system responders who participated in listening sessions, sharing their insights and experiences in supporting survivors of domestic violence. Serving survivors with complex trauma and behavioral health issues in the face of limited resources takes creativity, dedication, and tenacity. They demonstrated their dedication in the examples and insights they shared. The recommendations are, in part, a response to the challenges they noted, and are intended to serve their own efforts toward systemic reform.

The North Dakota Domestic and Sexual Violence Coalition (NDDSVC) and the Needs Assessment Planning Committee co-designed the study and provided vital context about the current response to domestic violence in North Dakota. The authors sincerely thank NDDSVC project leadership: Executive Director Seth O'Neill and Senior Project Director Suzanne Kramer-Brenna; and to the entire NDDSVC staff: Amie Britz, Heather Gerard, Britney Haga, Kayla Jones, Dana Mees, Lindsey Jo Pouliot, Katelyn Rivinhius, and Kayla Thein. Their insights and deep commitment to survivors and their safety came through in all the work done together.

Reaching survivors and practitioners from across North Dakota with the specific lived experience relevant to the study took many months and significant investment and collaboration. The authors are truly indebted to the following partners who helped make that outreach possible:

- North Dakota's domestic violence shelters and advocacy programs–together members of the North Dakota Domestic and Sexual Violence Coalition (NDDSVC), and those who hosted survivor and advocate listening sessions:
    - Abused Adult Resource Center
    - Community Violence Intervention Center
    - Domestic Violence and Abuse Center
    - Family Crisis Shelter
    - First Nation Women's Alliance
    - Rape and Abuse Crisis Center
    - Three Rivers Crisis Center

- Heartview Foundation

- Community Action Program of North Dakota and individual offices: Southeastern North Dakota Community Action, Dakota Prairie Community Action Agency, and Community Action Partnership-Dickinson and Williston Region.

Finally, the authors share their sincere hope that the collective voices woven into this report can build small yet meaningful bridges toward a stronger and more integrated system of services that will help survivors find their way to safety and wellness, ultimately ending domestic violence for all North Dakotans and their families.

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Appendices

Appendix A: Authors' Background

External Consultants and Report Authors: Laura Williams, Melissa Petrangelo Scaia, Mingyu Ma, and Hanna Sobhani

Laura Williams, MPA, HSDP is a strategist, consultant and trainer on ending gender-based violence through her consulting homes at Wise Action Consulting and the Global Alliance for Women's Safety and Equality. She was a co-founder and former Director of the Sexual Violence Justice Institute (SVJI) at the Minnesota Coalition of Sexual Assault, a U.S. training, technical assistance, and leadership development center for multidisciplinary teams responding to sexual violence. She has over thirteen years working directly with system-change oriented sexual assault response teams (SARTs)--first in the five-year pilot project that led to the creation of SVJI and later as its leader for over eight years. She has been in the movement to end sexual violence for over thirty years.

Ms. Williams served as the Director of Systems Advocacy for Global Rights for Women from 2021-2023, working on systems reform projects addressing gender-based violence in the U.S. and around the world. In this position she co-wrote numerous reports and papers with Ms. Scaia including a paper for UN Women, titled *Safe Consultations with Survivors of Violence Against Women and Girls*, and *Many Voices ND: A Needs Assessment on North Dakota's Response to Domestic Violence*.

Ms. Williams currently consults and trains on addressing and ending gender-based violence for UN Women, Wise Action Consulting and the Global Alliance for Women's Safety and Equality. In her current role she also conducted an assessment project for NDDSVC on its capacity to lead sexual violence prevention efforts culminating in the report, *Ready to Rise: Assessing NDDSVC's Capacity for Leading Health Equity-Focused Sexual Violence Prevention Efforts.* She also serves on the board of the Domestic Abuse Intervention Project, the home of the "Duluth Model."

Melissa Petrangelo Scaia, MPA has addressed gender-based violence (GBV) for nearly 25 years. She works part-time for Domestic Abuse Project in their men's perpetrator program as a group facilitator/mental health practitioner and coordinates the Minneapolis Coordinated Community Response (CCR) for domestic violence. She has also organized and led three other Coordinated Community Responses (CCRs). She is an international consultant for UN Women on GBV. As a researcher, international trainer, and co-author of *Domestic Violence Turning Points*, she focuses on addressing women's use of violence in a CCR and non-violence program. She also co-wrote a curriculum for working with perpetrators as fathers entitled, *Addressing Fatherhood with Men Who Batter*. She is the former Director of International Training at Global Rights for Women and former executive director of Domestic Abuse Intervention Programs (DAIP), also known as "the Duluth Model." In that capacity she led training and systems reform assessments around the world, co-authoring a number of reports

and manuals. She started as an advocate and then became the executive director of Advocates for Family Peace (AFFP) where she worked for 17 years. Her master's was on the effects of domestic violence on children and wrote her doctoral dissertation proposal on addressing post-separation domestic violence through supervised visitation. She serves on the steering committee for the US's National Network of Abuse Intervention Programs. Recently she was given the COMPASS award for her work on women's use of violence. She is also a court expert witness on domestic violence. Recently, she was awarded the Lifetime Achievement Award for Women in Public Service from Hamline University.

Mingyu Ma, MPP holds a Master of Public Policy from the University of Minnesota with a concentration in global feminist policy and international education. Her work is grounded in a systemic approach to gender justice, centering the experiences of women and girls across global contexts.

For the past three years, Mingyu served as a Program Manager at a nonprofit organization on international policy advocacy to address violence against women and girls. Prior to that, Mingyu worked in rural China during the COVID-19 pandemic to expand access to clean water and menstrual products for adolescent girls, addressing period poverty through community-based and gender-responsive solutions. Her approach combines policy analysis, survivor-centered research, and data-driven advocacy. She specializes in engaging survivors directly in research processes, then navigating large-scale qualitative data into holistic research to ensure survivor voices inform meaningful policy change. She has contributed to several institutional analysis and systems assessment projects in many countries, including work with USAID and the North Dakota Domestic and Sexual Violence Coalition (NDDSVC). She was also responsible for data analysis in the Institutional Analysis of the Minneapolis Police Response to Domestic Violence, helping identify structural gaps and opportunities for reform.

Hanna Sobhani, BA served as a research associate for Wise Action Consulting, bringing experience in program coordination, teaching, confidential hotline support and international education. She graduated Magna Cum Laude in Political Science with a Hispanic Studies minor and Phi Beta Kappa membership from the College of Saint Benedict and Saint John's University. She served two internships at Global Rights for Women one as a Legal and Communications Intern, and another as an International Women's Rights Policy Assistant. In this latter role she supported an assessment of the police response to domestic violence in the Republic of Georgia by documenting interviews, analyzing text, and scheduling meetings to enhance and implement a risk assessment methodology. She also researched, observed programs, and completed a published work comparing all 50 state standards and certifications needed to provide Batterer Intervention Program (BIP) services in the US. Ms. Sobhani's experience studying abroad in Chile and Greece and teaching in Japan, has equipped her with skills in teamwork and cross-cultural communication. She is skilled at problem-solving, managing projects, and building positive relationships with diverse groups. She is committed to creating inclusive, culturally competent environments as she promotes gender equality. She is also proficient in Spanish and Japanese.

Appendix B: Profile of Participating Survivors

NDDSVC, its member community and tribal-based programs, and Community Action Partnership local program staff were informed that Wise Action Consulting was looking to hear from survivors of domestic violence who have also had one or more of the following co-occurring issues: substance abuse, mental illness, or mental health which have impacted their ability to receive services and/or take care of themselves and/or their children.[22] The challenges could be short or long term, diagnosed or undiagnosed, but related to the abuse or violence. We acknowledged that these issues were typically those that required more services than most domestic violence programs are funded or designed to provide such that they likely required some level of interaction with other community behavioral health service providers.[2323]

The following are general characteristics of the thirty survivors who participated in group focus groups or individual listening sessions:

- Age: A range of 22 to approximately 65 years old.
- Relationship Abuse Occurrence: Most survivors had more than one experience of abuse.
- Domestic Violence Locations: When survivors chose to disclose (or were specifically asked), their abuse was experienced both outside and inside North Dakota - occurring in 14 other states and one other country (European) in addition to experiences in North Dakota. Within North Dakota, 11 different cities were indicated. Seven survivors did not identify where in the state the abuse occurred, and four survivors did not indicate any information about the location of the abuse.
- Advocacy Services Locations: When survivors chose to disclose, they noted receiving advocacy services in at least eight different North Dakota communities and in one other state.

[22] NDDSVC Membership Meeting of May 13, 2025. Slides from Wise Action Consulting.
[23] From slides for the Quick Scan sessions on February 10 and 12, 2025 and March 12, 2025.