New Mexico Intimate Partner Violence Death Review Team

Annual Report

2021

Findings & Recommendations from CY2018 Intimate Partner Violence Deaths

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The New Mexico Intimate Partner Violence Death Review Team (Team), also known as the Domestic Violence Homicide Review Team, is a statutory body enabled by the New Mexico Legislature under NMSA §31-22-4.1 (Appendix A). The Team is funded by the New Mexico Crime Victims Reparation Commission. Team coordination and staff services are housed at the Center for Injury Prevention Research and Education (CIPRE) in the Department of Emergency Medicine, University of New Mexico Health Sciences Center. The Team is tasked with reviewing the facts and circumstances surrounding each intimate partner and sexual violence related death that occurs in the State of New Mexico, with the aim of reducing the incidence of these deaths statewide. The Team is a multidisciplinary group of professionals who meet monthly to review the facts and circumstances surrounding each New Mexico death related to intimate partner violence (IPV) or sexual assault (SA). The 2021 report presents findings and recommendations from the Team's review of 2018 intimate partner violence and sexual assault related deaths.

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Acknowledgments
The New Mexico Intimate Partner Violence Death Review Team wishes to thank:

- The New Mexico Crime Victims Reparation Commission (CVRC), Director Frank Zubia and the entire Crime Victims Reparation staff and Commission, for their support of the Team's work;
- The Albuquerque Family Advocacy Center, the New Mexico Office of the Attorney General (OAG), and the Crime Victims Reparation Commission for assisting the Team with procuring meeting space;
- Rebecca Montoya Mora and Dr. Sarah Lathrop of the New Mexico Office of the Medical Investigator, for assistance with case identification and data collection, and;
- All of the criminal justice and community service professionals across the State of New Mexico who assisted with the record collection necessary for conducting effective case reviews.

The Team staff wishes to thank both appointed and invited Team members for all of the work that they do to generate the findings and recommendations contained in this report.

Finally, this report is written, and the Team's work is conducted, on behalf of and in memory of, intimate partner and sexual violence victims and the family members who have suffered the loss of their loved ones. Our wish is that our reviews and our subsequent recommendations improve responses to victims of intimate partner and sexual violence and ultimately prevent future injury and death associated with this violence.

Visit our website for more information about the New Mexico Intimate Partner Violence Death Review Team, our case review practice, and the production of findings and recommendations for this report. Visit ipvdrt.health.unm.edu to access our report archive and view multi-year data by person and incident characteristics.

Team Membership

Appointed Members

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Rosemary Cosgrove-Aguilar, Bernalillo County Metropolitan Court
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Cheryl Eaton, Jicarilla Behavioral Health Department
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Special Thanks to Out Going Team Members

Joel Hagaman, Marginalized Populations

Special Thanks to Team & Committee Chairs

Samantha Acuff, 2021 IPVDRT
Joe Hagaman, Marginalized Populations Committee
Cheryl Eaton, Native American Committee
Gail Starr, Teen Dating Violence Committee

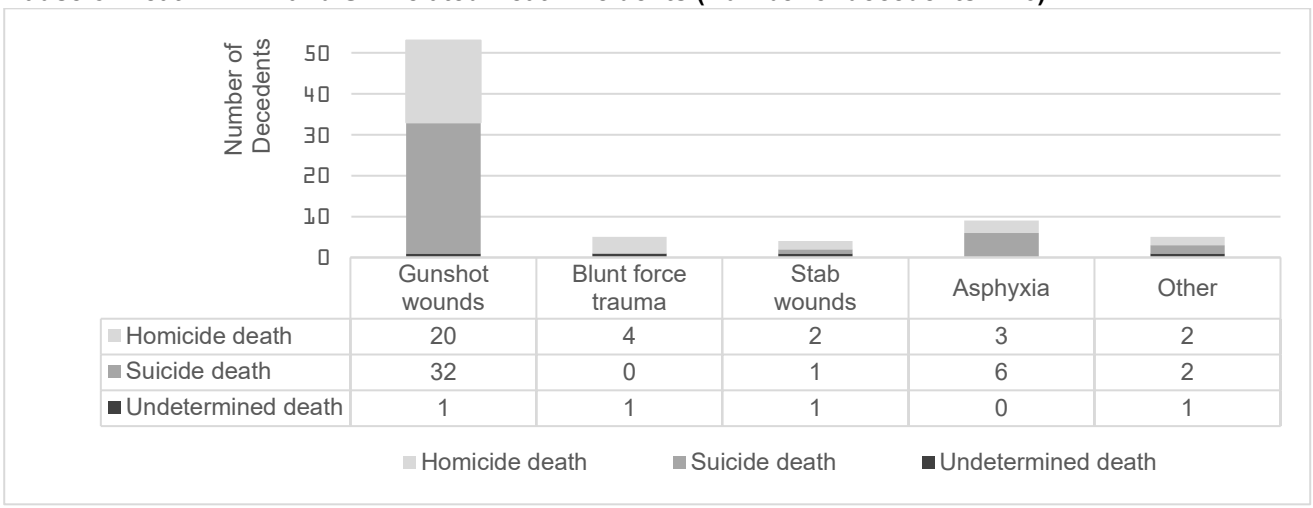
Incidents of Intimate Partner Violence and Sexual Assault Resulting in Death, CY2018

For case year 2018 (CY2018), the Team reviewed 66 incidents of intimate partner violence (IPV) or sexual assault (SA) that resulted in at least one death. In these 66 incidents, 76 people died: 31 died from homicide, 41 were acts of suicide, and four were classified as undetermined manners of death. The Team identified 25 additional IPV incidents resulting in a death for CY2018 that could not be reviewed due to insufficient information, incomplete investigations, or ongoing criminal court proceedings. IPV related death incidents occurred in 21 counties across the state and 31.8% of these incidents occurred in rural areas.

The Team reviewed 22 incidents of homicide, six incidents of murder-suicide, 34 incidents of suicide alone, and four incidents with an undetermined manner of death. Of 76 decedents, fifty-three deaths (69.7%) were the result of gunshot wounds, including 20 homicide deaths (26.3%). Nine deaths were the result of asphyxia, five deaths were the result of blunt force trauma, four deaths were the result of stab wounds, and two deaths were the result of overdose/poisoning. The cause of the remaining three death was unspecified. In four of the six murder-suicide cases, the causes of death for both the homicide and suicide decedents was gunshot wounds.

Seven incidents involved suspected sexual assault and six decedents in five death incidents received postmortem sexual assault analysis.

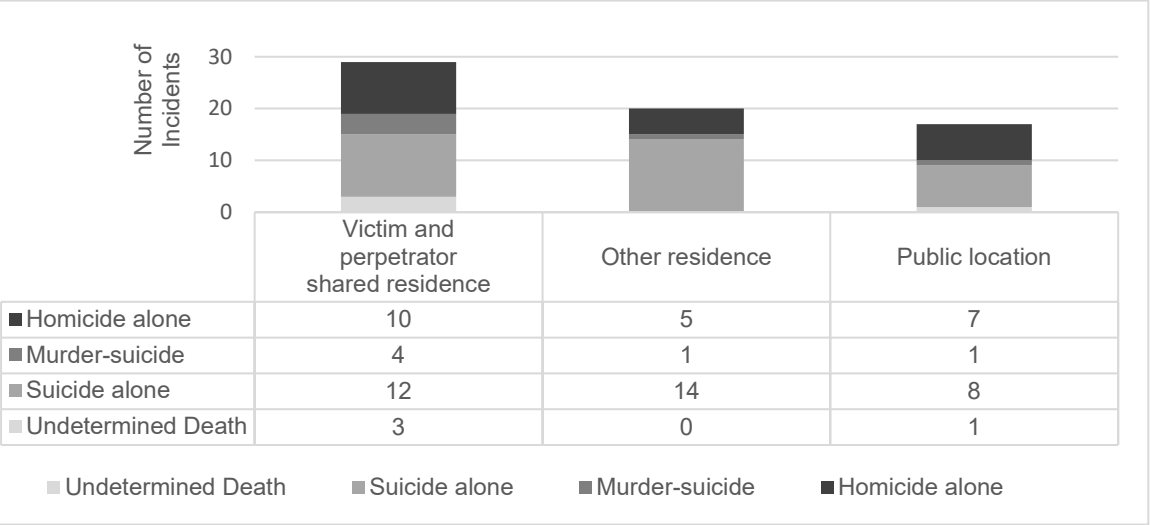
Cause of Death in IPV and SA Related Death Incidents (Number of decedents = 76)



	Gunshot wounds	Blunt force trauma	Stab wounds	Asphyxia	Other
Homicide death	20	4	2	3	2
Suicide death	32	0	1	6	2
Undetermined death	1	1	1	0	1

The Team reviewed five cases with IPV perpetrators who were prohibited by federal law from possessing a firearm. Seventeen death incidents (25.8%) took place in a public location, including eight in the front yard, parking lot, or driveway near a business or a personal residence, three in open space areas, and two in a motel room. Two cases occurred on the side of a highway or street, one in an apartment staircase, and one at a camp ground. The remaining 47 incidents occurred in a personal residence, with 29 incidents (43.9%) occurring in a residence shared by the IPV victim and IPV perpetrator. Three IPV related death incidents (4.5%) occurred with a minor child present. The figure on the next page shows the distribution of type of death incident by type of location.

Location of IPV and SA Related Death Incidents (Number of incidents = 66)



Criminal Charges

State criminal charges were filed against offenders in 12 of the 22 homicide alone incidents and all 12 prosecutions had a murder charge attached. In one of the four undetermined cases, the offender was charged with murder. However, it was later dismissed when the Office of the Medical Investigator (OMI) finalized the manner of death as undetermined. The table below shows the adjudicated charge and sentence range for all reviewed CY2018 homicide convictions.

There were 10 homicide alone incidents where no offender was charged:

- Four incidents were considered self-defense or justifiable homicide and in two additional cases prosecutors also declined to file charges against the suspect.
- Three incidents involved intervention by on-duty police officers, all of whom were deemed to have acted in legal capacity and none of whom were charged in the incident.
- In one case, the IPV victim's new partner was killed by the perpetrator, who committed suicide during the police response.

Conviction and Sentencing

Prosecutors obtained convictions for 11 individuals in death incidents where charges were fully prosecuted. In one case, the prosecutor requested dismissal after OMI finalized the manner of death as undetermined.

Five convictions resulted from a plea agreement and six from jury conviction. In incidents with a murder conviction, the minimum sentence on the most serious charge was five years for voluntary manslaughter and the maximum sentence was life imprisonment plus 20.5 years for a charge of first degree murder. One of the convictions involved a sentence that was partially suspended.

CY2018 Homicide Conviction Sentence Range by Charge Type (N = 12)

Most Serious Adjudicated Charge	Number of Convictions	Sentence Range in Years After Time Suspended (years in prison)
1st Degree Murder	2	Life to Life plus 20.5 years
2nd Degree Murder	6	12 to 30 years
Voluntary Manslaughter	3	5 to 7 years
Dismissed	1	Not applicable

Relationship and Person Characteristics in IPV and SA Related Death Incidents, CY2018

Relationship between the Intimate Partner Pair

For almost all reviewed cases, the death incident occurred either during or immediately following a threatened or actual incident of IPV or SA. In 15 incidents (22.7%), the intimate partner pair was married at the time of the death. Thirty-one incidents (47.0%) involved couples who were currently dating and seventeen incidents (25.8%) involved former spouses or dating partners. Three incidents involved a sexual assault between a victim and perpetrator with no prior intimate relationship. Fifteen couples (22.7%) shared biological or adopted children. Nineteen intimate partner pairs (28.8%) were in the process of separating at the time of the incident. The following table reports relationship characteristics for victim and perpetrator pairs involved in an incident of violence resulting in a CY2018 death reviewed by the Team.

Relationship between the Intimate Partner Pair (N = 66)

	Number of incidents	%
Relationship Status		
Spouse or Partner	15	23
Ex-spouse or Ex-partner	6	9
Boyfriend or Girlfriend	31	47
Ex-boyfriend or Ex-girlfriend	11	17
No known intimate relationship prior to the incident	3	5
In the Process of Separating	19	29
Habitation Status at Time of Incident		
Living together	36	55
Previously Lived Together	15	23
Never Lived Together	7	11
Living arrangement is unknown	8	12
Children		
Couple has any shared biological or adopted child(ren) of any age	20	30
Shared biological or adopted minor child(ren) in household	15	23
Any minor child(ren) in household	21	32
Step-child(ren) in household	11	17
History of Intimate Partner Violence within Pair		
Known history of intimate partner violence in relationship	43	65
At least one domestic violence police call for service	21	32
At least one arrest for intimate partner violence	16	24
Any history of a domestic violence order of protection between parties[1]	9	14
Criminal charges pending at time of incident	15	23
Any history of child custody cases	8	12

[1] Denotes a DVOP at any time during the relationship between the intimate partner pair.

IPV and SA Victims

IPV and SA victim refers to the victim of intimate partner violence or a sexual assault leading to a death incident. The IPV or SA victim may be the decedent, offender, or surviving partner in the death incident. For CY2018, there were 67 IPV and SA victims who were either the decedent, offender, or the surviving intimate partner. Victims ranged in age from 15 to 79 years old; the median age was 35 years. Most of victims (N= 59, 88.1%) were women. Seven IPV victims (10.4%) became parents when they were teenagers. Nine IPV victims (13.4%) had a prior arrest for a domestic violence offense. Eighteen IPV and SA victims (26.9%) were homicide decedents, four IPV and SA victims (6.0%) were suicide decedents and two IPV victims were decedents in an undetermined death incident. The table below presents background characteristics for IPV and SA victims in reviewed incidents.

Background Characteristics of IPV and SA Victims (N = 67)[2]

	Number of Victims	%
Gender		
Woman	59	88
Man	6	9
Transwoman	2	3
Race/Ethnicity		
White	30	45
Hispanic	22	33
Native American	7	10
Other	4	6
Unknown	4	6
Health		
Known history of alcohol abuse	11	16
Known history of Illicit drug use	12	18
Known history of depression or other mental illness	8	12
Known history of a chronic disease	5	7
Criminal History		
At least one prior arrest	19	28
At least one arrest for DWI	3	4
Convicted of at least one felony crime	2	3
At least one term supervised probation or parole	7	10
On probation or parole at the time of the incident	1	1
Intimate Partner Violence History		
Known history of intimate partner violence victimization	47	70
Known history of intimate partner violence perpetration	12	18
At least one arrest for domestic violence	9	13
At least one conviction for domestic violence	4	6
Party in at least one prior domestic violence order of protection	22	33

[2] One homicide case had two victims

IPV and SA Perpetrators

IPV and SA perpetrator refers to the identified perpetrator of intimate partner violence or sexual assault in an incident leading to a death. The perpetrator may be the decedent, offender, or surviving partner in the death incident. For reviewed CY2018 incidents, there were 66 IPV perpetrators. Perpetrators ranged in age from 16 to 74 years old; the median age was 35 years. Most (N=58, 87.9%) of the IPV and SA perpetrators were men.

Twenty-one perpetrators (31.8%) were homicide offenders. Of the 48 perpetrators who died during the incident, seven were both homicide offenders and suicide decedents, nine perpetrators (12.1%) were killed by a third party, and two had an undetermined manner of death. At the time of the incident, 36.4% of IPV and SA perpetrators were drinking alcohol and 27.3% were using illicit drugs.

Background Characteristics of IPV and SA Perpetrators (N=66)

	Number of Perpetrators	%
Gender		
Woman	8	12
Man	58	88
Race/Ethnicity		
White	28	42
Hispanic	24	36
Native American	9	14
Other	5	8
Health		
Known history of alcohol abuse	27	41
Known history of drug use (prescription)	22 (4)	33 (6)
Known history of depression or other mental illness	36	55
Known history of a chronic disease	5	8
Use of alcohol at time of death incident	24	36
Use of illicit drugs at time of death incident (prescription)	18 (9)	27 (14)
Criminal History		
At least one prior arrest	38	56
At least one arrest for DWI	18	27
Convicted of at least one felony crime	18	27
At least one term supervised probation or parole	25	38
On probation or parole at the time of the incident	7	11
Intimate Partner Violence History		
Known history of intimate partner violence victimization	9	14
Known history of intimate partner violence perpetration	50	76
At least one arrest for domestic violence	28	42
At least one conviction for domestic violence	10	15
Party in at least one prior domestic violence order of protection	21	32

Known Contacts with Service Providers for IPV and SA Victims and Perpetrators

	IPV and SA Victims (N = 67)		IPV and SA Perpetrators (N = 66)	
	Number of victims	**%**	**Number of perpetrators**	**%**
Service Contact History				
Health care services	22	33	24	36
Domestic violence related friends and family support	13	19	0	0
Domestic violence related services	5	7	4	6
Mental health services	3	4	7	11
Substance abuse treatment program	3	4	6	9
Government services	2	3	2	3
Children, Youth and Families Department contact	1	1	1	2

Contacts with Service Providers

In addition to formal criminal and civil legal systems, the Team evaluates other known service contacts for both IPV and SA victims and perpetrators.[3] The most common service contacts were with health care providers: approximately one third of IPV and SA victims (N=22, 33.3%) and perpetrators (N=23, 34.3%) had at least one contact with a medical provider through primary care or the emergency department. Other common service contacts were with substance abuse treatment providers: Four victims (6.1%) and six perpetrators (9.1%) had at least one contact with a substance abuse treatment program. Three victims (4.5%) and seven perpetrators (10.4%) used mental health services. Three perpetrators and four victims attended court ordered domestic violence counseling programs. Of those, two perpetrators and one victim attended a court ordered batterer's intervention program.

Secondary Offenders and Victims

At times, individuals outside of the intimate partner relationship are identified as a party to IPV-related homicide, as either the decedent (a secondary victim) or offender (a secondary offender). The Team reviewed 12 incidents involving secondary offenders and victims. Nine incidents involved secondary offenders who committed an act resulting in homicide. Three of these incidents involved an offender who was an on-duty police officer acting in their official capacity. Two secondary homicide offenders were relatives of the IPV victim, two were the IPV victim's new partner, and two were acquanintances of the IPV victim. Two of these secondary offenders were charged and convicted of murder in relation to the incident.

For CY2018, the Team reviewed four incidents involving secondary victims. Three secondary victims were the new intimate partners of the IPV victims and were killed by the victim's former partner. One secondary victim was a family member of the intimate partner pair who was injured from a gunshot wound by the IPV perpetrator, but survived.

Team Recommendations

Legislation/Policy

Create New Mexico legislation that requires that firearms are securely stored away from children and other unauthorized users. In CY2018, the Team found that almost 70% of all IPV related deaths were the result of gunshot wounds. Securely storing firearms decreases the likelihood of incidents of accidental shootings, intimate partner homicide, and suicide[4] Currently, 12 states have some type of firearm safe storage legislation. Lawmakers should review safe storage laws enacted in these states to identify how these jurisdictions assigned responsibility for purchasing or providing locking devices to gun owners.

[3] Our identification of known contacts with services outside the criminal and civil justice system is limited. We document known contact from prior court history and investigative documents related to the homicide and other prior interactions with the police or courts.

[4] AMA Journal of Ethics. 2018. "Law and ethics conversations between physician and patients about firearms in the home." Retrieved Aug. 25, 2021 (https://journalofethics.ama-assn.org/article/law-ethics-and-conversations-between-physicians-and-patients-about-firearms-home/2018-01)

Revise the Family Violence Protection Act to require all respondents to relinquish firearms while restrained by a domestic violence order of protection. This may be accomplished by amending subsection A (2) of the NMSA 40-13-5, to remove the requirement of the judge's opinion of a "credible threat" in addition to the granting of the order of protection before mandating the relinquishment of a firearm. The team also recommends a review of the provisions of NMSA 40-13-5, 40-13-13 and NMSA 40-17-(1–13) to align the provisions for firearm relinquishment across the statues.

Explore the option of creating a new tax on private firearm purchases, with the proceeds earmarked for domestic violence services. The Team found that almost 70% of IPV homicide deaths were the result of a gunshot wound. It is recommended that expansion of domestic violence services along with increased publication of those services may create more opportunity for survivors to access support services.

Law enforcement

Create model policies to improve accountability and quality control measures for the investigation, documentation, and reporting of incidents of violent death by law enforcement agencies statewide. The Team observed a number of cases in which prior calls for service were properly documented and demonstrated knowledgeable and thorough responses to victims by police. However, there continues to be an unknown number of instances in which calls for service are not documented and investigations are abbreviated. The Team supports the recommendation of the International Association of Chiefs of Police who advocate for the creation and implementation of model policy that includes standardized investigations for all domestic violence related incidents, including standardized evidence collection protocols, required domestic violence incident reporting forms that include a lethality assessment, and the utilization of on scene domestic violence advocates to support survivors.[5] The policies should also include continuing education for law enforcement officers about investigation, emergency orders of protection, summons, warrants, and appropriate removal of firearms. Agencies should ensure that senior leadership receives proper training on best practices in investigation and documentation, including documentation for testimony. Leadership should hold their staff accountable for following established protocols.

Increase capacity of law enforcement agencies to respond to intimate partner and sexual violence by improving the availability of victim-centered resources and advocate support. Law enforcement agencies are short staffed and officers often are called upon to do advocacy work. Developing an advocate workforce may ensure appropriate response while also lessening the workload of officers responding to these incidents of violence. Victim advocates with training on the dynamics of domestic violence should be called to the scene to assist with survivors, victims, and child witnesses and their adult caretakers to ensure that survivors are receiving appropriate services. These advocates should be employed by community-based victim advocate groups. Advocates may assist victims with orders of protection, safety planning, shelter access, referrals to other services such as counseling, and aftercare. Advocacy organized in an ongoing case management structure may also provide a point of contact for victims following the incident and improve victim access and use of services.

Law enforcement agencies should ensure officers are provided increased training on all aspects of intimate partner violence, including the dynamics of the violence and the appropriate documentation of incidents that involve IPV. An increase in the required amount of both academy training and continuing education for law enforcement professionals are steps toward improving the responses of officers towards victims of violence, as is collaborating with service providers to receive the training. The Team recommends that agencies collaborate with victim advocates and service providers to train officers on risk assessment and trauma informed response for survivors of and witnesses to violence.

Law Enforcement agencies should ensure that officers are provided effective training regarding culturally specific differences and barriers within marginalized communities in New Mexico. Cultural differenced and barriers can create a challenge for both survivors of violence and officers in responses to violence. Failure to understand cultural differences and barriers, particularly in Native American, African, Middle Eastern, and Asian communities, can lead to ineffectual and/or detrimental contact and

[5] International Association of Chiefs of Police. 2016. "Domestic Violence Model Policy." Retrieved Dec. 11, 2017 (http://www.theiacp.org/MPDomesticViolence

responses to intimate partner violence issues within marginalized communities.

Provide continuing education to law enforcement officers on the New Mexico Family Violence Protection Act (NMSA Chapter 40, Article 13) to ensure consistent application of the law and improve continuity in the use of domestic violence orders of protection across jurisdictions. The team reviewed cases where law enforcement reports identified a lack of clarity about whether a household member crime had occurred or missed opportunities for emergency protection orders or other types of relief at the scene. While these problems were observed in a minority of cases, each observation highlights an important area for continued education on the definition of household member, qualifying abuse acts, and best practices for emergency protection order petitions. These laws are subject to change as are the community resources available for victims. As such, the Team recommends ongoing continuing education about both criminal and civil domestic violence law in order to ensure consistent application of the law across jurisdictions.

Law enforcement agencies should develop best practices regarding the use of lapel cameras and recording reporting requirements. The Team supports the recommendation of the International Association of Chiefs of Police who advocate for the development of a model policy that includes when and where to record, when recording may not be appropriate, and specific download, storage, and retention requirements[6]. The Team also recommends that agencies create guidance for officers on incorporating recorded material into their written reports. These policies should include provisions for regular review and auditing.

Victim Services

Provide follow-up and case management services to victims after incidents of intimate partner and sexual violence. Service providers are in a unique position to offer survivors of violence resource lists and referrals after incidents of violence. Advocates, especially those in rural areas, should work with victims who would like to file domestic violence orders of protection, seek medical treatment, or seek therapy. These providers should also work with the local district attorney's office to ensure that victims of crime have access to advocacy services.

Identify gaps and leverage existing resources to improve the distribution of and access to domestic violence services, especially in rural areas. The Team recognizes that additional resources are needed and that those needs and gaps vary by community. The Team also recommends that agencies look for ways to maximize existing resources to improve access to services whenever possible. One strategy may involve establishing Community-Coordinated-Response (CCR) or Multi-Disciplinary Teams (MDT) in specific locations that would facilitate collaboration between criminal justice and community organizations to include cross-training and joint scene response when responding to incidents. The Native American Committee suggests forming CCRs or MDTs within tribes that collaborate with local agencies and state and federal partners. Almost 32% of reviewed deaths occurred in rural areas of the state. The Team recognizes that additional resources, including remote service delivery options, like telemedicine, are needed and recommends agencies look for ways to maximize existing resources to improve access to services whenever possible.

Promote awareness and understanding of the danger and characteristics of stalking. In CY2018, 29% of the intimate partner pairs had abuse histories that included stalking behaviors.The team has noted that there is a need to promote awareness of the characteristics of stalking and the dangers as well as provide training to service providers and law enforcement. Victim advocates struggle to provide effective guidance regarding legal and law enforcement responses to stalking due to a need for training and a need for increased public awareness. Providing funding for training to educate and prepare victim advocates and to support public education/engagement efforts is necessary.

Providers should ensure that victim advocates are provided effective training regarding culturally specific differences and barriers within marginalized communities of New Mexico. Cultural differences and barriers can create a challenge for both survivors of violence and advocates. Failure to understand cultural differences and barriers can lead to ineffectual and/or detrimental responses to a specific survivor's experience, particularly in Native American, African,

[6] International Association of Chiefs of Police. 2019. "Body Worn Cameras". Retrieved Aug. 25, 2021 (https://www.theiacp.org/sites/default/files/2020-06/BWCs%20June%202020.pdf)

Middle Eastern, and Asian communities, and fail to provide meaningful safety options to a survivor.

Courts

Offer ongoing training to improve and maintain court staff capacity to engage with victims and perpetrators of domestic violence in both a trauma-informed and culturally sensitive manner. The Team found that 58% of perpetrators and 28% of victims had at least one prior criminal court contact, and 36% of perpetrators and 40% of victims had at least one prior civil court contact (DVOP, divorce, custody/parentage, or bankruptcy). This training should provide information not only on safe and appropriate response to incidents of physical abuse but also should help judges and court staff members identify controlling behaviors, stalking, and other forms of abuse. Educational content should be produced in collaboration with professionals who work in domestic and sexual violence advocacy and service provision and be culturally appropriate for the intended audience.

Courts should evaluate both the need and the capacity for monitoring offenders, both those awaiting trial for violent crimes and those sentenced to probation. An evaluation will help identify the resources necessary to develop an appropriate system of compliance monitoring to meet the needs of each jurisdiction. Relatively few pretrial monitoring programs exist statewide, with only a handful of counties having programs at the district or magistrate court level. When available, pretrial programs should monitor offenders who are awaiting trial for violent crimes, including those charged with either felony or misdemeanor domestic violence.

Magistrate courts also have insufficient funding for supervising probation sentences, including those involving convictions for misdemeanor domestic violence. Court officials at all levels should ensure that providers of court ordered services associated with conditions of release are reporting violations and lack of compliance in a timely fashion. Monitoring compliance with domestic violence offender treatment/batterer intervention programs requires collaboration between courts and domestic violence service providers. The Team recommends courts require this treatment to be completed in a CYFD certified domestic violence offender treatment program.

Probation and Parole

Address policy and resource gaps in the monitoring and supervision of offenders, including support for professional monitoring of sentence compliance and attendance of court ordered rehabilitation and Batterer Intervention Programs. A review of IPV perpetrator criminal histories in CY2018 showed that 38% had at least one prior contact with state probation and parole services. Eleven homicide offenders were serving a probation or parole sentence at the time of the death incident. Even when arrested for new crimes, offenders were not always charged with probation or parole violations. In a few cases, violations were processed but did not necessarily result in changes to the terms of supervision. The Probation and Parole department should clarify and train officers on the best practices of working with offenders who violate substance abuse orders or commit additional crimes, including notifying the court of additional charges. This recommendation is consistent with the National Institute of Justice position[7] that courts hold violent offenders accountable for abiding by conditions of release and impose consequences when they do not.

Medical, Mental, and Behavioral Health Care Services

Require continuing education units about intimate partner violence for professional certifications and licensing in medical professions, allied health professions, social work, counseling, substance abuse treatment, psychology, and psychiatry. Educational requirements in these professions should include culturally appropriate training in how to screen for, ask questions about, and identify risks for IPV, safety planning, and referrals for appropriate IPV interventions for individuals of all ages. Medical professionals should also be trained on documentation of IPV, as required by the New Mexico Family Violence Protection Act [See NMSA §40-13-7.1]. These enhancements may come from curriculum development at schools for higher learning, IPV competency requirements for licensure, or required IPV continuing education, depending on the educational requirements of each respective occupation. Training should be designed and implemented by IPV victim advocates and focus on improving IPV identification as well as knowledge on available services for referral in local communities.

[7] National Institute of Justice. 2009. "Practical Implications of Current Domestic Violence Research: For Law Enforcement, Prosecutors, and Judges." Retrieved Dec. 11, 2017 (https://www.ncjrs.gov/pdffiles1/nij/225722.pdf).

Medical providers treating patients with chronic health conditions should screen for substance abuse, IPV, depression, and suicidal ideation. Providers should be offered continuing education on trauma informed care among chronically ill patients. Patients at risk for IPV, depression, and suicidality should be referred to appropriate service providers.

Identify, inventory, and leverage existing resources to eliminate barriers to mental health services around the state, especially in rural communities. The Team recognizes the need for additional mental health resources that are trauma informed, long-term, and are available in rural areas. The Team recommends the development of culturally appropriate and holistic services for teens and young adults, military veterans, the elderly, those who threaten and/or attempt suicide, and Native American populations. The Team also recommends that mental health care providers work to improve both visibility and accessibility of existing services and provide opportunities for education on issues related to both warning signs and intervention for suicide, self-harm, firearm storage and weapon safety, and dealing with crisis situations. The Native American Committee recommends improved availability of and access to mental health services that are culturally, linguistically, and age-appropriate for tribally affiliated individuals.

Identify, inventory, and leverage existing resources to eliminate barriers to substance abuse services around the state, especially in rural communities. The Team recognizes the need for additional substance abuse treatment resources that are trauma informed, long-term, and also exist in rural areas. The Team recommends the development of culturally appropriate and holistic services for teens and young adults, military veterans, the elderly, and Native American populations.

Improve and coordinate follow-up and case management to individuals who seek medical, mental, or behavioral health treatment, particularly in rural areas. The Team observed cases where over 33% of victims and over 35% of perpetrators had sought treatment for physical or mental health conditions. Often, individuals do not complete prescribed treatment. The Team recognizes that there is a shortage of services in all of these areas throughout the state and that when these services exist, coordination is lacking. Coordination of services can ensure that individuals are accessing and adhering to the services they need, including long-term services. Coordinated case management also gives more opportunities for providers to screen their patients for IPV and identify other needs, such as family counseling, grief services, and primary prevention. The Team recommends cross-training for service providers in each of these areas.

Increase the availability of mental health services for aging individuals, particularly those with chronic medical issues. The loss of quality of life appears to be a contributing factor for marginalized persons with little or no prior history of intimate partner violence to engage in an extreme form of violence against themselves and/or their partner to resolve their perceived lack of quality of life.

Cross-Cutting Recommendations for the Community

Improve universal awareness and recognition of intimate partner violence. The Team recommends expanding public awareness education aimed at improving the recognition of IPV. These efforts should work to raise awareness on the warning signs of intimate partner violence, lethality risk factors, safety planning, and advice on how to talk about violent relationships. These efforts should also help community members identify intimate partner violence, including controlling behaviors, stalking, and other forms of abuse. Prevention advocates should coordinate local resources and a broad set of stakeholders to develop community capacity to engage in IPV prevention. The team recommends defining the target audience broadly, including culturally and age appropriate messaging for children, parents, organization, and adults in the community. These activities should be inclusive of boys and men of all ages, providing education on male violence victimization and perpetration as well as engaging men as allies in IPV and sexual assault prevention.

Increase public outreach efforts on how and when to report witnessed incidents of intimate partner violence and sexual assault. Public information initiatives should provide details not only on safe and appropriate response to incidents of physical abuse. Service providers can support these efforts by increasing visibility of services and resources in their communities. Provider outreach efforts should be designed for local communities, including work places, and be culturally and age appropriate for targeted audiences.

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