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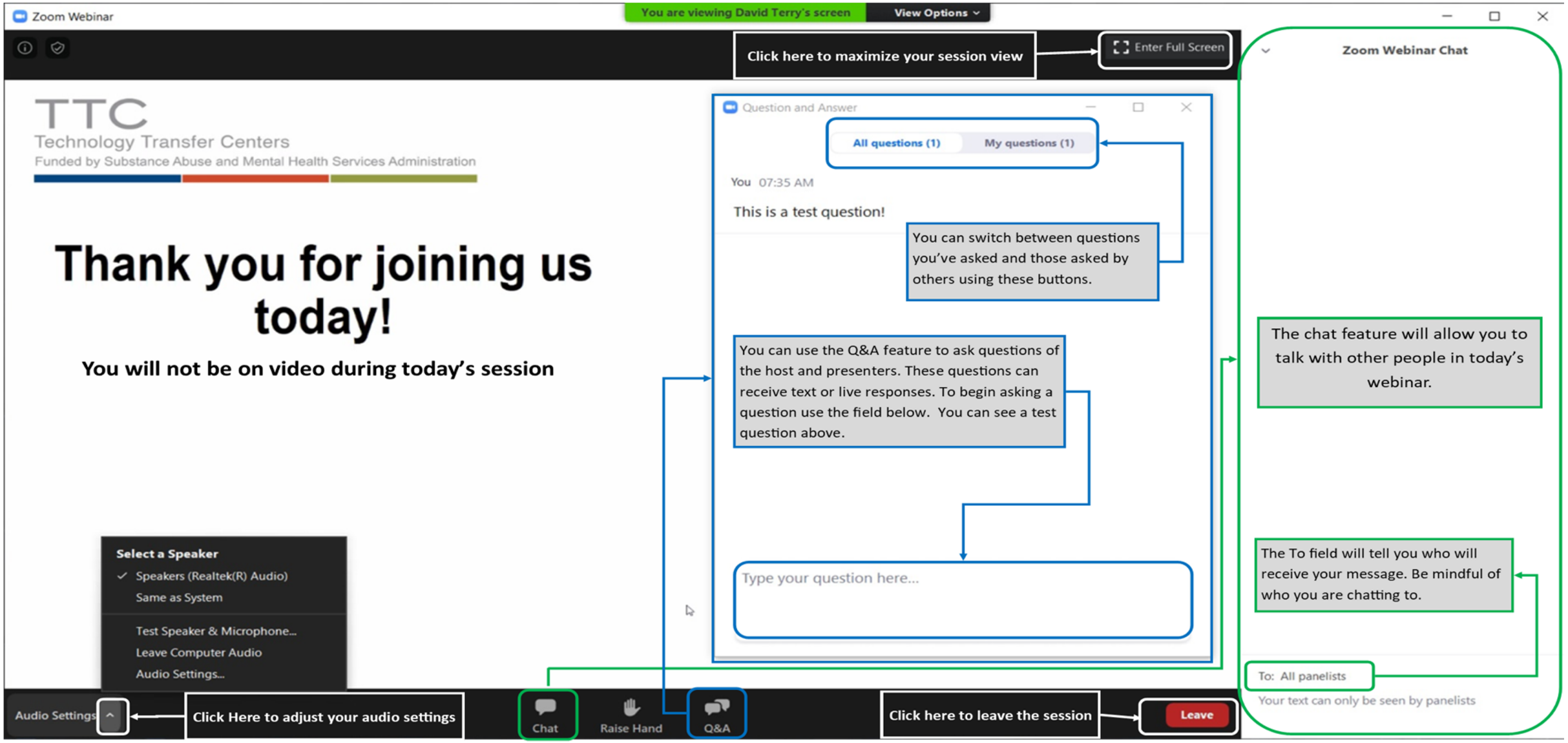

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NATIONAL Center on Domestic Violence, Trauma & Mental Health

Working at the Intersection of Intimate Partner Violence and Mental Health

Intimate Partner Violence, Suicidality, and Disabling Psychiatric Conditions: Unique Risks, Needs, and Strategies

Wednesday, September 9, 2020

Presented by:

Carole Warshaw, MD, Director, NCDVTMH

Gabriela Zapata-Alma, LCSW, CADC, Director of Policy and Practice on Domestic Violence and Substance Use, NCDVTMH

Housekeeping Items

- We have made every attempt to make today's presentation secure. If we need to end the presentation unexpectedly, we will follow-up using your registration information.
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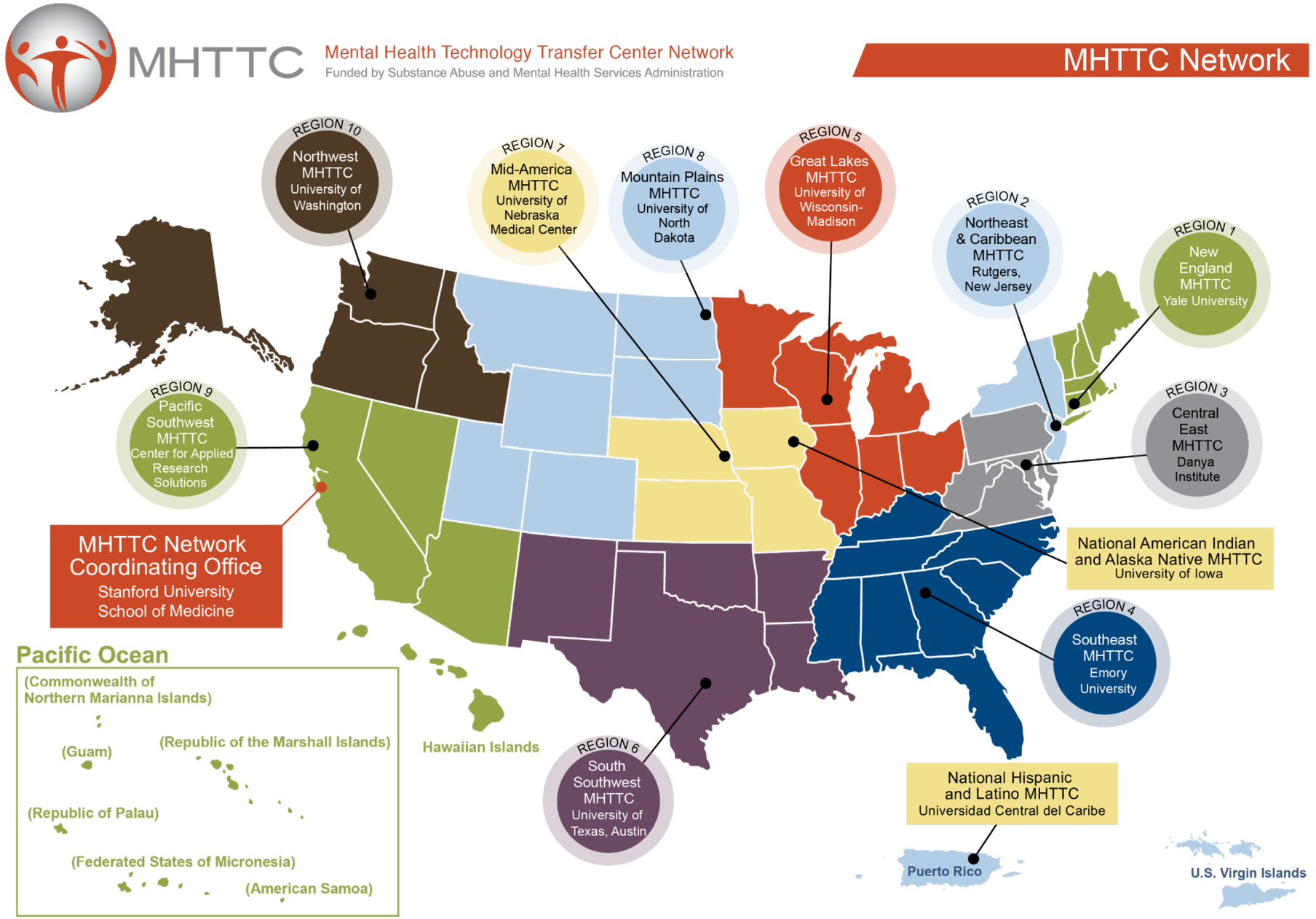
The session recording and slide deck will be posted on our website within a few days.

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

- The MHTTC Network accelerates the adoption and implementation of mental health related evidence-based practices across the nation
    - Develops and disseminates resources
    - Provides free local and regional training and technical assistance
    - Heightens the awareness, knowledge, and skills of the mental health workforce
- 10 Regional Centers, a National American Indian & Alaska Native Center, a National Hispanic & Latino Center, and a Network Coordinating Office
- www.mhttcnetwork.org

Connect with Your MHTTC at www.mhttcnetwork.org



Working at the Intersection of Intimate Partner Violence and Mental Health

- 3 sessions
- July 8, August 12, September 9
- 10am PT / 11am MT / 12pm CT / 1pm ET
- Register at bit.ly/IPV-series

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NATIONAL Center on Domestic Violence, Trauma & Mental Health

Northeast & Caribbean MHTTC

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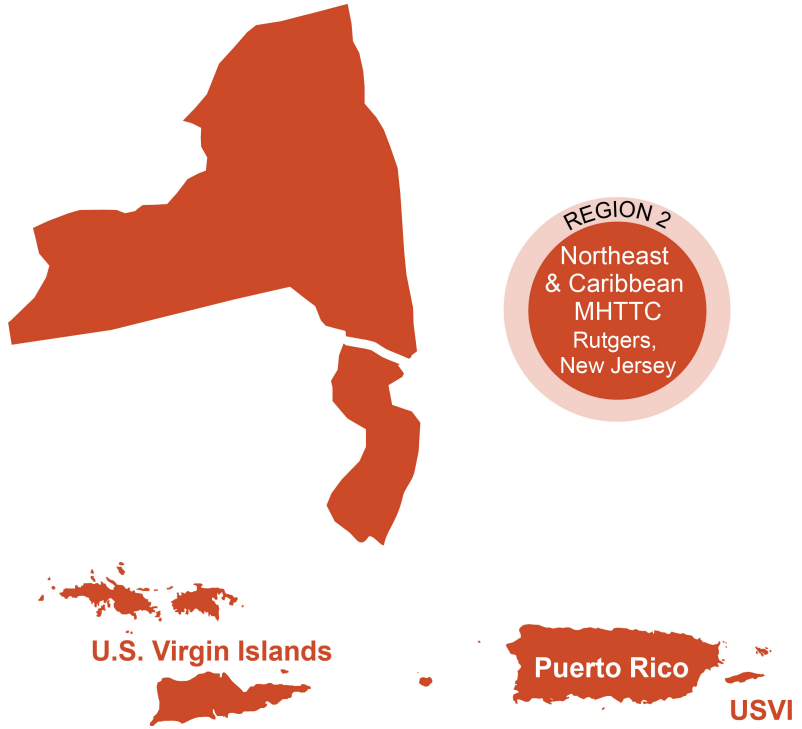

Northeast and Caribbean (HHS Region 2)
MHTTC Mental Health Technology Transfer Center Network
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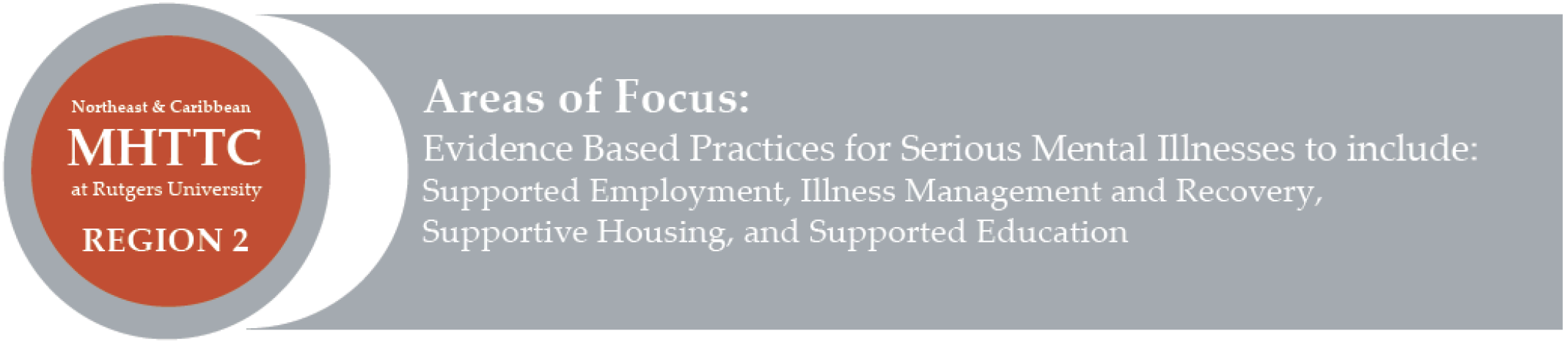
Areas of Focus



Foundational Skills: Trauma Informed Care, Motivational Interviewing, Suicide Risk Assessment and Prevention

Additional Topics: Peer Providers, Working with Affectional and Gender Minorities, Mental Health Recovery in the Hispanic and Latino Communities, Role of Religion and Spirituality in Recovery, and Staff Self-Care Strategies

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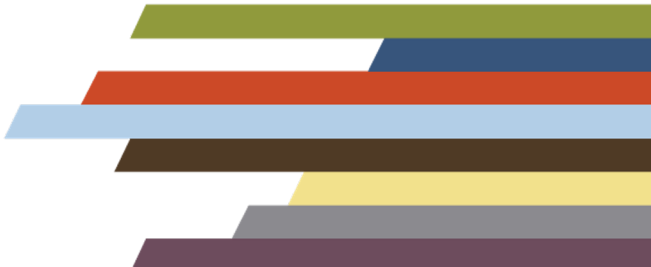
At the time of this presentation, Elinore F. McCance-Katz served as SAMHSA Assistant Secretary. The opinions expressed herein are the views of Carole Warshaw, MD and Gabriela Zapata-Alma, LCSW, CADC, and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.



Evaluation Information

The MHTTC Network is funded through SAMHSA to provide this training. As part of receiving this funding we are required to submit data related to the quality of this event.

At the end of today's training please take a moment to complete a **brief** survey about today's training.

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NATIONAL Center on Domestic Violence, Trauma & Mental Health

Working at the Intersection of Intimate Partner Violence and Mental Health

Intimate Partner Violence, Suicidality, and Disabling Psychiatric Conditions: Unique Risks, Needs, and Strategies

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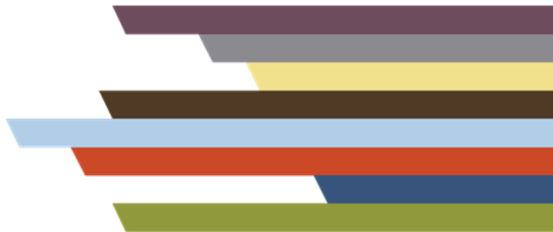


Presenters

Carole Warshaw, MD, is the Director of the National Center on Domestic Violence, Trauma & Mental Health and a faculty member in the Department of Psychiatry at the University of Illinois. Dr. Warshaw has been at the forefront of developing collaborative models and building system capacity to address the mental health, substance use and advocacy concerns of survivors of DV and other trauma, and to create accessible, culturally responsive, domestic violence- and trauma-informed services and organizations.

Gabriela Zapata-Alma, LCSW, CADC, is the Director of Policy and Practice on Domestic Violence and Substance Use at the National Center on Domestic Violence, Trauma & Mental Health, and faculty at University of Chicago's School of Social Service Administration. Gabriela brings over 15 years of experience supporting people impacted by violence, mental health conditions, substance use disorders, trauma, housing instability, and HIV/AIDS; providing counseling, training, advocacy, and policy consultation; and leading programs using trauma-informed approaches, Motivational Interviewing, harm reduction, gender-responsive care, Housing First, and third-wave behavioral interventions.

NATIONAL Center on Domestic Violence, Trauma & Mental Health

Intimate Partner Violence, Suicidality, and Disabling Psychiatric Conditions: Unique Risks, Needs, and Strategies

September 9, 2020
Session 3 of 3
Working at the Intersections of Intimate Partner Violence and Mental Health

NATIONAL Center on Domestic Violence, Trauma & Mental Health

U.S., DHHS, Administration on Children, Youth and Families, Family and Youth Services Bureau, Family Violence Prevention and Services Program:

Special Issue Resource Center Dedicated to Addressing the Intersection of Domestic Violence, Trauma, Substance Use, and Mental Health

- Comprehensive Array of Training & Technical Assistance Services and Resources
- Research and Evaluation
- Policy Development & Analysis
- Public Awareness

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

Learning Objectives

1. Describe the multi-directional relationships between IPV, suicidality, and disabling psychiatric conditions for survivors of IPV
2. Assess the potential role of intimate partner violence in precipitating or exacerbating mental health crisis
3. Actively collaborate with survivors of IPV to develop individualized, person-centered safety strategies in mental health crisis prevention and recovery planning, including IPV-informed psychiatric advance directives

Our work is informed by…

Framework for Thinking about IPV in the Context of Mental Health, Psychiatric Disability, and Suicide

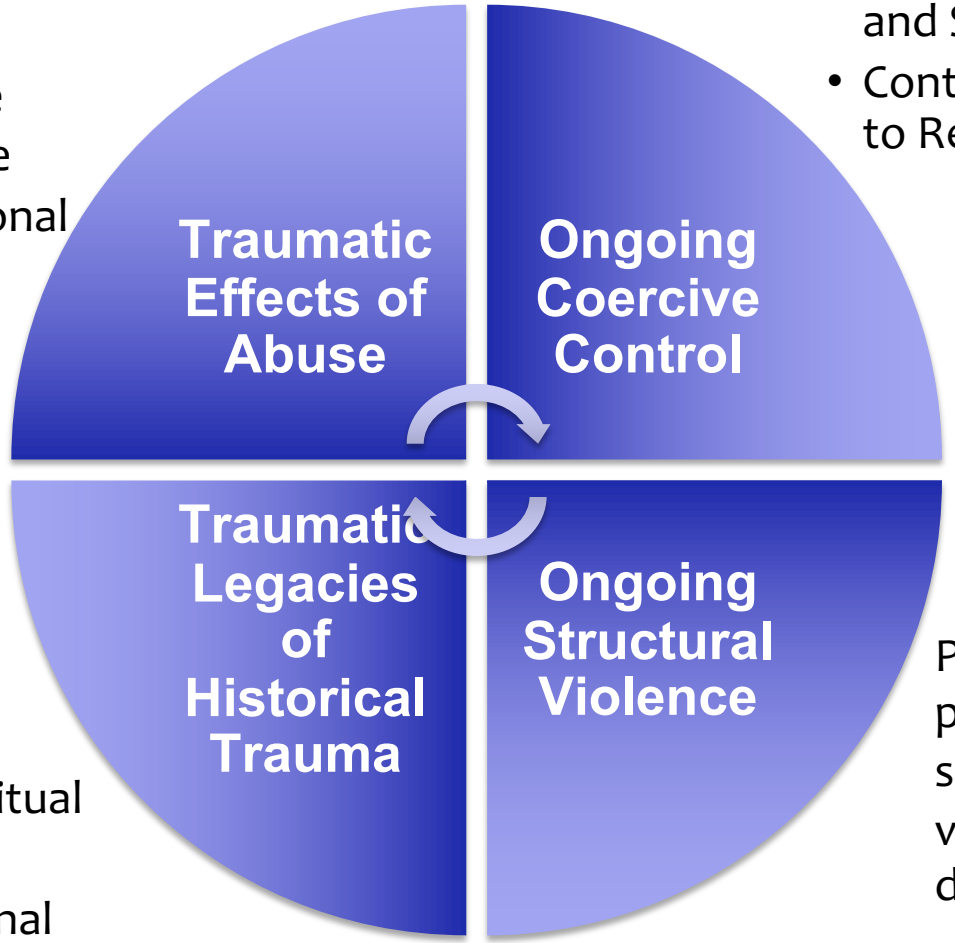
Thinking About Mental Health in the Context of IPV: Implications for Clinical Practice

- IPV has serious health, mental health and substance use-related effects.
- Survivors of IPV often experience multiple types of trauma
- People who access mental health and substance use disorder treatment services experience high rates of IPV
- Abusers actively use mental health and substance use issues against their partners as a tactic of control, compromising their partners' wellbeing and undermining the effectiveness of mental health treatment
- Partnering with DV programs and implementing policies and best practices for addressing trauma and IPV are critical to the provision of quality care

Thinking About IPV, Trauma, Suicide, and Psychiatric Disability in a Broader Social Context

- Health
- Mental Health/Suicide
- Substance Use
- Intergenerational
- Interpersonal
- Economic

- Undermining Sanity and Sobriety
- Controlling Access to Resources



- Health & MH
- Economic
- Social
- Cultural & Spiritual
- Environmental
- Trangenerational

Policies that perpetuate structural violence & discrimination

Warshaw 2015

What Do We Know About the Relationships Between IPV, Disabling Psychiatric Conditions, and Suicide?

Research Overview

IPV Among People Experiencing Disabling Psychiatric Conditions (DPCs):
A Nationally Representative Sample

Past Year IPV: Population-weighted prevalence

- Women: 20.0% vs. 5.3% no DPCs
- Men: 6.9% vs. 3.1% no DPCs

Past Year Sexual IPV Among Women: Relative odds

- 30 in 1,000 women with DPCs vs. 4 in 1,000 women without DPCs

People living with a disabling psychiatric condition vs. not were:

- 2x to 5x more likely to experience emotional, physical, and sexual IPV
- 2x as likely to experience mental or emotional difficulties
- 5x more likely to attempt suicide as a result of IPV
- More likely to disclose to health professionals than to social networks

Khalifeh, Oram, Trevillion, Johnson, and Howard, 2015

Prevalence of IPV in Psychiatric Settings

- **Lifetime Prevalence of IPV in Inpatient Psychiatric Settings**
  - Women: 34% to 63% (Post et al. 1980; Carmen et al. 1984; Hoffman & Toner, 1988; Cascardi et al. 1996)
  - Men: 14% to 48% (Post et al. 1980; Hoffman & Toner, 1988)
- **Previous Year Prevalence of IPV in Inpatient Psychiatric Settings**
  - Women: 22% to 76% (Hoffman & Toner, 1988; Carlile, 1991; Cascardi et al. 1996; 92% in the Heru study)
  - Men: 48% (Hoffman & Toner, 1988; 93% in the Heru study).
- **Lifetime Prevalence of IPV in Psychiatric Emergency Rooms**
  - 30%-60% (Cluss et al., 2010)
- **Episodically Homeless Women with Disabling Psychiatric Conditions**
  - 80% lifetime physical IPV; 40% lifetime sexual IPV (Goodman et al., 1995)

Howard, Trevillion,.Khalifeh, Woodall, Agnew-Davies and Feder, 2010

Exposure to ongoing abuse can exacerbate symptoms and precipitate mental health crises, making it more difficult to access resources, and increasing an abuser's control over their partner's life.

IPV Increases Depression and PTSD Risk

IPV and Depression

- Estimated Rates: 3x risk for MDD; nearly 2x risk for PPD
- Risk Factors: Recency and severity of IPV and other trauma; Increases suicide risk

IPV and PTSD

- Estimated Rates: 45%-84%; weighted mean prevalence 61%
- Risk factors: Cumulative burden: duration, severity and number of types of IPV and other trauma; psychological and sexual violence; low social support; prolonged stress/ongoing risk; system responses; Increases risk for MDD + suicide

IPV and Complex Trauma

- Risk factor: Prolonged exposure to interpersonal trauma

All impact ability to access resources; Increase risk for abuser control

What Helps: Safety, access to resources, social support; IPV-informed treatment

Oram et al. 2014; Bacchus et al., 2018; Beydoun et al., 2012, Coker et al., 2002; DeJonghe et al., 2008; Coker et al., 2004;, Kaysen et al., 2003; Herman, 1992

IPV Increases Suicide Risk

Higher Rates of Suicidality/ Attempts Among IPV Survivors

- **Overall Rates**
  - **3x** risk for suicidal ideation; **6x** for teens
  - **4x** risk for suicide attempts; **9x** for teens
- **Community Settings**
  - **23%** of IPV survivors reported past suicide attempts vs. 3% no IPV
  - **36.8%** of IPV survivors seriously considered suicide

Higher Rates of IPV Among People Who Attempt Suicide

- **Inpatient Mental Health Setting**
  - **>90%** women hospitalized post-suicide attempt reported current severe IPV
- **Health Care Setting**
  - **2.5x** higher rates of physical IPV and **2.8x** higher rates of emotional IPV among Black women who attempted suicide vs. who had not

Silverman, et al., 2001; Kaslow, et al., 1999; Dillon, 2013; Devries, et al., 2013; Coker 2002, Pico-Alfonso 2006, Seedat 2005, Heru 2006

IPV and Suicide: Additional Risk Factors

- Types of Abuse: Physical abuse, physical + psychological abuse, emotional violence; sexual violence/marital rape; childhood sexual abuse
- Risk for potentially lethal assault
- Chronic or disabling health conditions
- Hopelessness, substance use, psychological distress
- PTSD and/or Depression
- Fear, entrapment, inability to escape

Jewkes, 2008; Cavanaugh, et al., 2011; Kaslow, et al, 2002; Leiner et al., 2008; Maselko & Patel, 2008; O'Connor & Ibrahim, et al., 2017; Devries et al., 2013

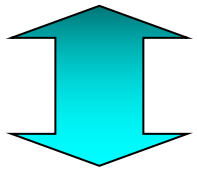
Intimate Partner Violence and Psychotic Experiences in Four U.S. Cities

- **Experiencing at least one form of IPV significantly associated with 4 types of psychotic experiences** (strange experiences, paranoia, thought insertion, hallucinations) for men and women.
- **Strongest associations: Threats and sexual IPV;** not physical IPV
- **IPV associated with >3x odds of reporting at least one psychotic experience** vs. none

Shah, Von Mach Fedina, Link, DeVylder, 2018

Mental Health Coercion in the Context of Psychiatric Disability: Risk Versus Vulnerability?

People who perpetrate IPV use mental health and substance use issues to control their partners



Stigma, poverty, discrimination, and institutionalization compound these risks

- Induced debilitation (controlling meds, disrupting routines, coerced use)
- Coerced overdose
- Control of treatment
- Undermining of sanity, credibility, parenting, and recovery
- “She was out of control”

WHY DOES THIS WORK?

- Reports of abuse attributed to delusions
- Symptoms of trauma misdiagnosed as MI
- Assumptions that psychiatric disability precludes good parenting
- Internalized stigma

IPV and Disabling Psychiatric Conditions: Unique Barriers

- People living with disabling psychiatric conditions are at higher risk for abuse and experience additional layers of trauma
  - High prevalence of lifetime abuse and PTSD, including in relation to experiences of psychosis, medication side effects, and hospitalization
  - More likely to experience abuse from a range of sources, including within families, in public spaces, in institutional or residential service settings, in addition to IPV
  - Responses to previous trauma + internalized stigma may increase risk
- Risk of abuse is exacerbated by experiences of poverty, housing instability, institutionalization, unsafe living conditions, and reliance on caregivers;
  - IPV is often a precipitant to homelessness and is particularly prevalent among women with psychiatric disabilities who experience a lack of housing
- Survivors also face a lack of gender-specific treatment, services, and spaces; challenges to accessing DV services; and additional custody hurdles

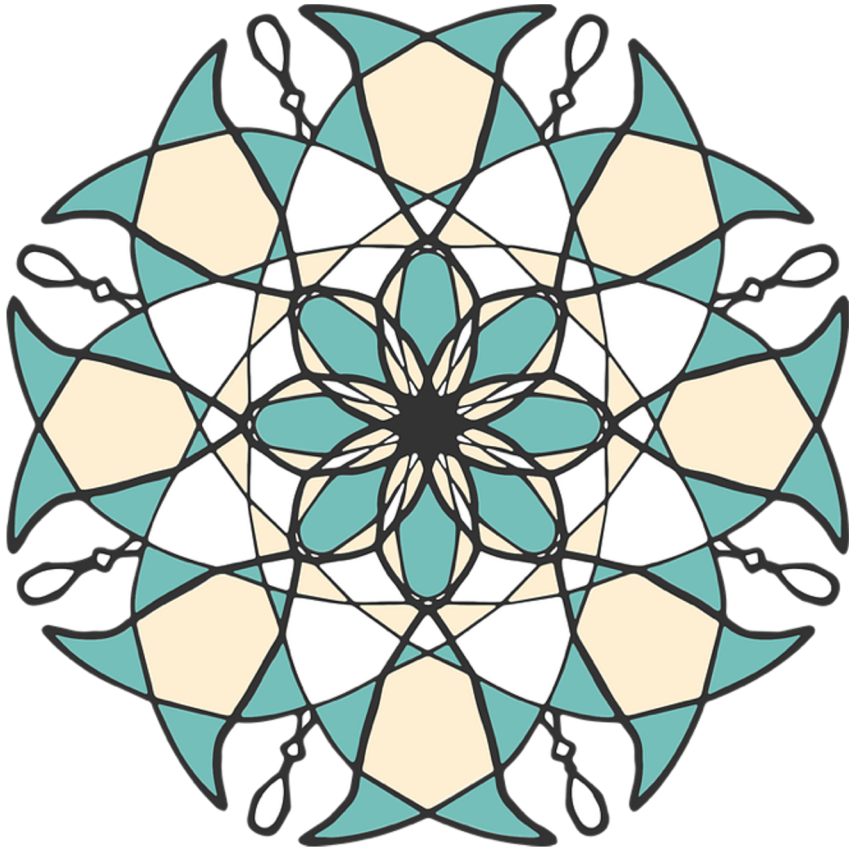
Warshaw & Zapata-Alma, 2020; Goodman et al., 1995; Khalifeh et al., 2015; Shah et al., 2018; Gilroy et al., 2016; Ramos et al., 2004; Harris, 2001

Working with Survivors of Intimate Partner Violence Who Experience Disabling Psychiatric Conditions and/or Suicidality

IPV-Specific Interventions

Consider Multiple Domains of Safety

- **Mental Health Context**
  - Self-harm; Harm to others
- **Trauma Context**
  - Retraumatization; Potentially risky coping strategies
- **Substance Use Context**
  - Increased risks; Overdose, Other medical effects
- **IPV Context**
  - Ongoing danger & coercion from partner; Revictimization by other people and systems



Warshaw, et al., 2009

Psychotropic Medication in the Context of IPV

- Discuss pros and cons
- Ensure choice
- De-stigmatize
- Enhance sense of control
- Ensure that abuser does not control
- Develop plans to take meds safely
- Be careful about reducing vigilance

Policies and Practices that Address IPV-related Safety Concerns

- **Immediate safety during crisis calls or telehealth encounters**
- **Immediate safety** in clinical setting and upon discharge
- **Suicidality and homicidality** in the context of trauma, abandonment, resistance, coercion, access to resources and support, and threats by an abusive partner
- **Safety planning around mental health and substance use coercion**, including re: medication, access to services and support, maintaining healthy routines
- **Ongoing safety** planning re: physical and psychological danger including for children
- **Workplace Safety**

Policies and Practices Regarding Involvement of Family Members: Attend to IPV

- **Develop strategies to determine whether accompanying party is safe**
- **Recognize ways an abusive partner or family member may try to control the assessment process** and manipulate providers' perceptions (appear concerned; provide false information). ***Do not ask:***
  - In the presence of a someone not identified as safe
  - During couples therapy; in the presence of children
  - A partner or family member for corroboration
  - A potentially abusive partner for collateral information
- **Use professional translators; Discuss limits of confidentiality**
- **Ask about advance directives, power of attorney, control of finances, guardianship, medication, treatment, and discharge planning**

Addressing Safety Issues:

Suicide Risk in the Context of IPV

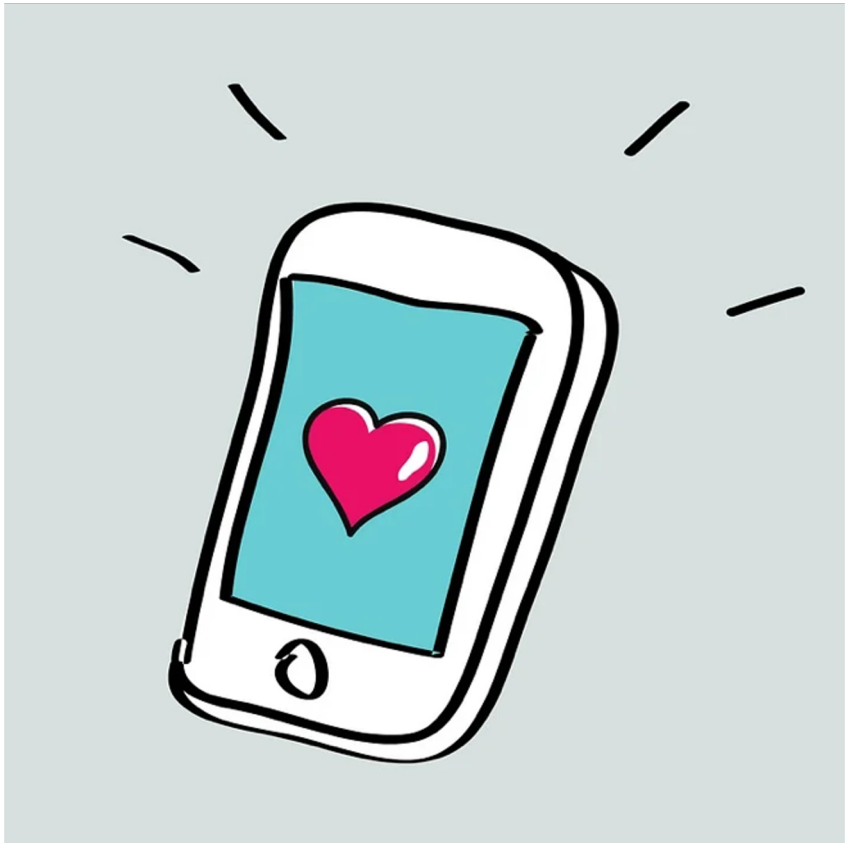
Responding to Suicidality in the Context of IPV

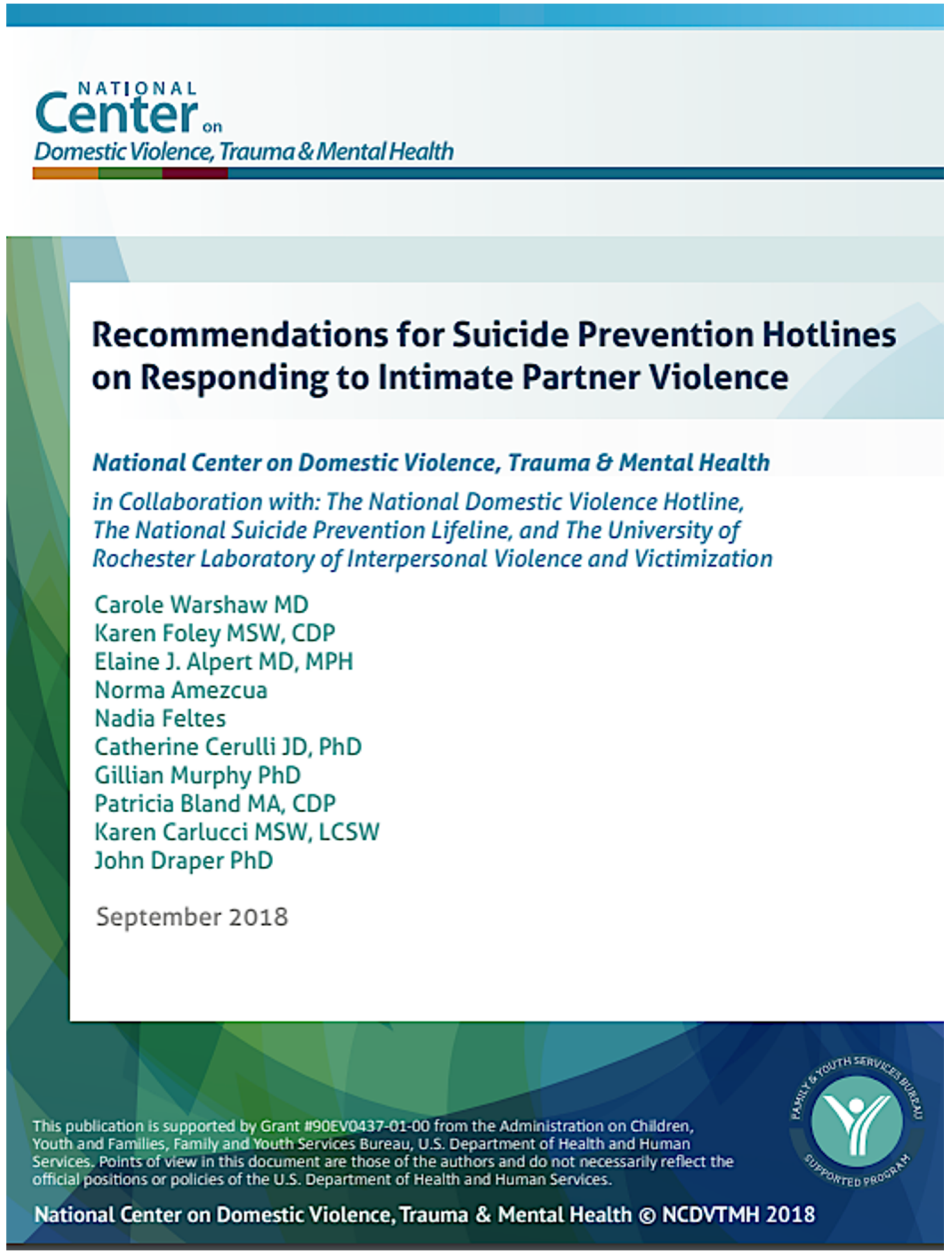
- **Assess routinely, discuss frankly**
  - **Survivors**
    - May feel like only option; may be an act of resistance
    - Risk may increase after leaving, before chance to recover
    - May result from abandonment, particularly in the face of early trauma
  - **Perpetrators**
    - Depression; Abandonment/separation; Pathological jealousy
- **IPV-specific treatment for depression and suicidality:**
  - Grady-Nia Project; Mindfulness-Based Stress Reduction, HOPE
- **Collaboration between DV and mental health crisis services and hotlines**

Kaslow, et al., 2010; Johnson & Zlotnick, 2012; Dutton et al., 2013

Addressing IPV in the Context of Suicide Helplines and Crisis Lines

- When people call crisis lines, the crisis they are experiencing and the help they are seeking may be related to IPV
- Understanding the role IPV may be playing in a caller's suicidal feelings or intent and attending to the additional safety issues that may be at play are critical for responding in safe and helpful ways.





Recommendations for Suicide Prevention Hotlines on Responding to Intimate Partner Violence

http://www.nationalcenterdvtraumamh.org/publications-products/recommendations-for-suicide-prevention-hotlines-on-responding-to-intimate-partner-violence/

Thinking About Suicidality in the Context of IPV: Considerations for Crisis Line Calls

- **The person calling is not alone:**
  - **Crisis line perspective**: Asking if the caller is alone and then discovering that someone is there with them may come as a relief.
  - **IPV perspective:** Person might be an abusive partner or family member, contributing to the crisis or making the caller less safe.
- **The person calling seems genuinely concerned about their partner's suicidality or mental health status:** Requests advice about what to say or information about how to access emergency and/or inpatient psychiatric services.
  - **Crisis line perspective:** Concern and support reassuring and helpful in planning for safety and support.
  - **IPV perspective:** Caller might be an abuser trying to have partner committed as tactic of control and/or to undermine their partner's ability to retain custody of their children (Foley 2015).
- **Recognizing how IPV can play out on a crisis call** provides additional perspectives for listening and responding to callers who are dealing with both suicidality/mental health crises and IPV.

Helpline Calls: Assessing and Responding to Imminent Risk and Immediate Danger

- **Suicide is the primary issue:** If abuse has been disclosed and the caller indicates it is not safe to talk about the abuse,
  - Ask only yes/no questions to determine immediate IPV-related safety needs
  - Let the caller know that if they want you to call the police, they can let you know by using a pre-established code phrase
- **Danger from an intimate partner is the primary issue**:
  - Ask if it is safe to talk and if the person calling feels they are in danger.
  - Immediate risk assessment: Whether the person calling wants to involve the police; whether there is a safer time or place for the person to call back; whether there is a safe way to contact them and whether it is safe to leave a message

Helpline Calls: IPV is Identified but No Immediate Danger..

- **Ask if it is safe to talk** and if the caller wants to talk about the abuse they are experiencing. Discuss immediate safety concerns and priorities. Once suicide-related concerns have been addressed, offer referrals to a local DV program or hotline in addition to mental health referrals
- **If the caller is at risk but does not want to pursue a DV referral** or is unable to do so, validate their courage in making a disclosure, support their efforts to engage in help-seeking, and collaborate with the caller on developing strategies to increase their safety.
- **Be cautious about engaging the assistance of a potentially abusive partner.** If a caller indicates that they are being abused by an intimate partner, involving that partner in suicide safety planning can potentially place the caller at greater risk.

The National Domestic Violence HOTLINE
1.800.799.SAFE (7233) • 1.800.787.3224 (TTY)

Suicide Crisis Calls That Intersect With Intimate Partner Violence (IPV)

Call Comes into the Lifeline Crisis Line

Proceed with Lifeline's Suicide Assessment and Listen for IPV "Red Flags"

- The person is afraid all the time
- The person has been isolated from family/friends
- The person "can't do anything right"
- The person is yelled at, criticized, humiliated by their intimate partner
- The person is to blame for their intimate partner's behavior

(For more see IPV Tip Sheet)

Proceed with Suicide Intervention to include IPV Safety Planning

- How to remain safe in the relationship
- How to file police report and restraining order
- How to leave safely/have an escape route
- How to safety plan with children
- How to cope with emotions
- How to stay safe in the home

(For more see Safety Planning Tip Sheet)

Referrals

Provide referrals to The Hotline:

1-800-799-SAFE (7233) or thehotline.org

and/or other local DV agencies

Determine Level of Suicide Risk: Safety Risk Assessment

Are you alone now? Is it safe to talk on the phone now?

YES

NO

Determine Safety Priorities

- Would you like to stay on the phone and talk, or would you prefer to go someplace safer and call me back?
- Do you want to get help from the police right now?
- Have you been having thoughts of harming or killing yourself (or someone else)? Have you ever tried to harm yourself or end your life?
- Has the person you're currently with ever threatened you or hurt you or someone you love?
- Create safety code word with caller

Suicide is Primary Concern

- Proceed with suicide assessment and intervention, including considerations for IPV-specific risks
  - Advise responders not to discuss IPV with potentially abusive partner
  - Advise police of abuse/presence of weapons in the home
  - Advise hospital intake personnel to perform IPV assessment, safety planning and/or linkage with DV/rape crisis services

Imminent Danger from Abusive Partner is Primary Concern

- If the caller chooses to remain on the phone, discuss immediate escape routes
- Connect the caller with 911 if they or their children are in immediate danger
- Make arrangements to get back in contact to discuss mental health and/or substance abuse referral options once caller is safe. Share contact information for The Hotline

(For more see Recommendations for Suicide Prevention Hotlines on Responding to Intimate Partner Violence)

Intimate Partner Violence Safety Planning Tip Sheet

What is Safety Planning?

Safety planning is helping a caller build a blueprint for a safer life. It is a personalized, practical plan that includes ways to remain safe while in a relationship, planning to leave or after leaving. A good safety plan will have all of the vital information a caller needs and be tailored to their unique situation.

NOTE: Safety planning is NOT telling the caller what to do or blaming the caller.

Assessing Immediate Danger

In order to determine what type of safety plan should be developed in conjunction with the caller, it is first important to identify if the caller might be in immediate danger. Below are some questions you can ask to determine if the caller is in immediate danger.

- Is that person there right now?
- Is it safe enough for me to ask you a few questions?
- Do you feel you are in immediate danger?
- Does this person have a weapon? Are they threatening to use it?
- Who else is there (e.g. children)? Can you leave to a safe place?

If caller is in immediate danger from a partner or others:

- Suggest that caller contact police or offer to call police on their behalf
- Give contact information for National Domestic Violence Hotline (1-800-799-SAFE) and/or local DV agency
- Make arrangements to get back in contact to explore mental health referral options once the caller is safe

How to Assess Safety Further IF THERE IS NO Immediate Danger Threat

Ask callers what they have done thus far to protect themselves and their children. Ask if they think this will work again and if not, what they think might work. You could say, "Some people tell me...Do you think that would work?" Examples can include:

- Calling a friend, so the partner knows someone is listening
- Removing guns from the home if possible or hiding guns, knives or other weapons
- Sending the children to someone else's home when there is increased danger
- Keeping keys and money available outside of the house, and keeping a full tank of gas
- Storing important papers and records (or copies) in a safe location
- Leaving the house overnight

Beyond Immediate Crisis: Addressing Ongoing Safety; Offering Information and Support

- Let survivors know that Intimate partner violence is common but never justified
- Discuss the dynamics of abuse and its consequences for adult survivors and their children.
- Talk about how with support, many survivors are able to end the violence in their lives
- Discuss legal options as well as community and online resources specific to their needs
- Talk about strategies survivors can use to keep themselves and their children safe, increase their support and reduce their isolation, and nurture their own (and their children's) resilience and well-being

IPV Safety Planning: Issues Specific to Psychiatric Disability and Mental Health Coercion

- **Physical and Emotional Safety**
  - Withholding medication; sleep deprivation; coerced treatment; controlling access to treatment; sabotaging recovery; custody threats
  - Control of finances, guardianship, insurance; Advance Directives
  - Medication: Control, choice, impact on cognition and safety
  - Anticipate trauma triggers; distinguish from necessary vigilance
  - Suicidality; suicide threats by partner
- **Adapt to cognitive abilities and ability to process information during crisis**

Integrating Safety Planning into Recovery Tools and Advance Directives

Safety Planning with People Who Are Experiencing a Psychiatric Disability

- **Safety Planning**
  - Planned response to crisis
    - Psychiatric Advance Directives; WRAP ™
  - Specialized safety planning
    - WRAP ™ and other recovery wellness tools and strategies
- **Psychiatric Hospitalization**
  - Opportunity to refuse calls or visits from abusive partner
  - Maintain phone contact with children when possible
  - Ask about abuse on admission and safety planning on discharge

Advance Directives

- **Declaration for Mental Health Treatment**
  - Presumes Incompetence; 2 witnesses, MD evaluation to change
  - “Attorney-in-fact”: access to records, decision-making
  - Discuss as part of safety planning
- **Power of Attorney for Health Care**
  - Presumes Competence; Can change at will
  - “Agent”: access to records, decision-making
  - Discuss as part of safety planning

Psychiatric Advance Directives

If I cannot advocate for my self …

…Please do this….and not this….

…Involve this person….and not this one….

Affords protection if keeps abusive partner from being involved

Dangerous if abuser is “attorney-in-fact” or “agent”

Wellness Recovery Action Plans

- **WRAP™ is a structured system for wellness self-management through**
  - Planned responses that reduce, modify or eliminate symptoms
  - Planned response from others when you need help to make a decision, take care of yourself or keep yourself safe

- **6 components + Wellness Toolbox**
  - Daily Maintenance Plan
  - Triggers
  - Early Warning Signs
  - Symptoms that Occur When the Situation is Worse
  - Crisis Plan
  - Post Crisis Plan

Copeland, 1977

Recovery Tools and DV Safety Planning

- **Daily Maintenance Plan**:
  - What I am like when I'm safe and my well-being is attended to
  - Things I can do every day to optimize the safety and well-being of myself and my children
- **Triggers**
  - Anticipating things that could be signs of impending violence
  - Things that when they happen make me feel that I'm not (and/or the children aren't) safe
  - Things I can do to optimize safety
  - Anticipating own responses and things I can do to stay calm and think clearly

Copeland & NCDVTMH, 2007

Recovery Tools and DV Safety Planning

- **Early Warning Signs**
  - Signs that danger is escalating
  - Signs that that I'm having trouble managing
  - Who I can call, What I can do
- **When the Situation is Getting Worse**
  - Things that indicate the situation is getting worse (danger is escalating) and I can still take action for myself and my children
  - The specific things I must do; Who is safe to involve

Copeland & NCDVTMH, 2007

Recovery Tools and DV Safety Planning

- **Crisis Plan**
  - What I'm like when I'm safe and my needs for well-being are met
  - What it looks like when the situation is out of my control
  - Who is safe, who I want involved
  - Who I don't want involved
  - What I want done; What is likely to help
- **Post Crisis Plan**
  - Safety planning on discharge
  - Mobilizing resources and support

Copeland & NCDVTMH, 2007

Supporting Survivors of IPV Who Are Experiencing Disabling Psychiatric Conditions: Additional Strategies

- **Partnerships with DV Programs**: Cross-training, cross-referral, co-location; supports for survivors in both settings
  - Partnerships between DV programs and peer recovery support organizations and providers
  - Partnerships between DV transitional housing and housing first programs and MH supported housing providers
  - Support for DV/trauma crisis beds and peer respite services
- **Training for Crisis Line Staff** on responding to suicide, mental health crises, and IPV
- **Gender Responsive Services** for survivors of gender-based violence
- **IPV-Informed Treatment:** Trauma-informed, IPV-specific approach that addresses mental health coercion; Tailored PTSD treatment

Supporting Survivors of IPV Who Experience Disabling Psychiatric Conditions: IPV-specific Interventions + Evidence-Based Trauma Treatment

- **Cognitive Restructuring for PTSD**
  - CBT for PTSD effective even if cognitive difficulties (Mueser et al., 2009; Mueser 2018)
- **Trauma Recovery Empowerment Model (TREM) + TREP Skill Development:**
  - Intrapersonal, interpersonal and global skills (Harris, et al, 2002)
- **Exposure-Based Therapies**
  - Prolonged Exposure Therapy (PET) and Eye Movement Desensitization and Reprocessing (EMDR) - handful of studies with promising results (Swan et al., 2017; Perlini et al. 2020)
  - Trauma-focused care (PET or EMDR n=108) promising for people with PTSD + psychosis including symptom improvements, decreased revictimization and other adverse events vs. waitlist at 6-months (van den Berg et al., 2016)

Expert Consensus-Based Guidelines for Treatment of Trauma-Related Disorders and Early Psychosis

- Treatment modalities of choice: individual therapy (or family or conjoint therapy if no abuse)
- Treatment approaches for addressing both symptoms of trauma and psychosis: anxiety or stress management and psychoeducation
- Treatment intervention for addressing sx of psychosis: case management
- Lack of consensus on:
  - Sensorimotor or movement interventions for trauma
  - Exposure interventions for psychosis

(Cragin et al., 2017)

IPV- and Trauma-Informed Treatment and Services

- Experiences of lifetime trauma and IPV are common, particularly among people living with disabling psychiatric conditions.
- IPV and trauma are associated with increased distress, problem severity, and reduced access to resources that aid in safety, stability, recovery, and quality of life.
- Actively implementing an Accessible, Culturally Responsive, and Trauma-Informed (ACRTI) approach can enhance resilience, safety, access, and effectiveness of mental health care for persons served as well as staff and systems.
- Offering IPV-informed trauma treatment can improve recovery outcomes, safety, and quality of life for people living with disabling psychiatric conditions.
- Trauma-informed approaches require us to transform the conditions that perpetuate individual and structural violence.

In Sum, Ensure that....

- Collaborative **referral relationships are established** with local DV programs
- All **staff are trained** on how to ask about and respond to IPV
- **Questions about IPV and mental health and substance use coercion are incorporated into screening and assessment processes**,
- **Best practices for responding to trauma and IPV are incorporated** into counseling and treatment; telehealth and crisis line practices; safety planning processes, guardianship, and PADs; peer support and wellness recovery activities; medication; information management, documentation and EHRs; reporting and information sharing; discharge planning; and referral protocols, including protocols for staff experiencing IPV
- **Staff have the** personal, collegial, supervisory, and HR **supports they need** to respond both effectively and compassionately

NATIONAL Center on Domestic Violence, Trauma & Mental Health

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Resources for Mental Health and Substance Use Treatment and Recovery Support Providers

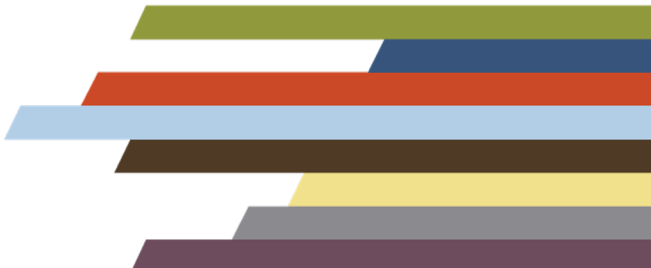
At the National Center on Domestic Violence Trauma & Mental Health (NCDVTMH), one of our priorities is to support collaboration between the domestic violence (DV) field and the mental health and substance use disorder treatment and recovery fields. Our work is designed to enhance system responses to survivors of intimate partner violence (IPV) who are experiencing the mental health and substance use-related effects of IPV and other lifetime trauma. A 2012 study conducted by NCDVTMH in partnership with the National Association of State Mental Health Program Directors (NASMHPD) found that the majority of states who participated had a strong interest in further coordination and/or training on these issues.

The information that follows is intended to support mental health and substance use disorder treatment and recovery support providers in their work with survivors of IPV and their children. You will find toolkits, best practice guidelines, webinars, research reviews, and policy briefs to help inform your practice. These can be found below under:

www.NationalCenterDVTraumaMH.org

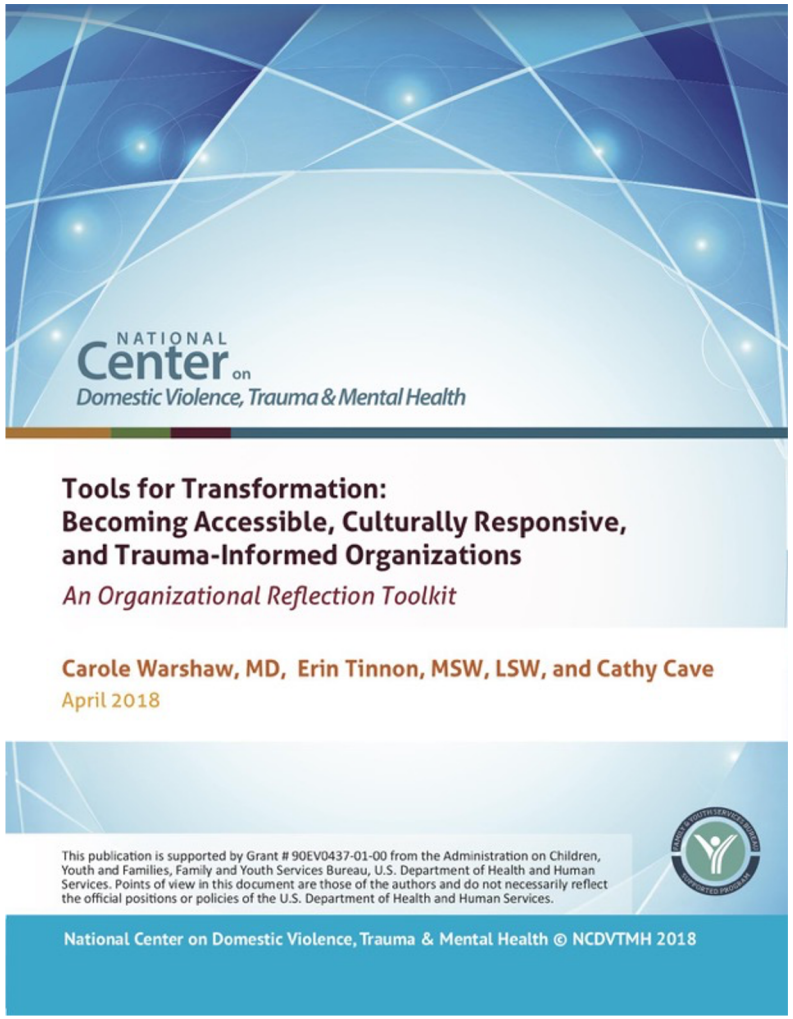
Thank You!

Q&A with Presenters



Mental health treatment in the context of IPV builds upon on foundation of trauma-informed approaches

Tools for Transformation:
Becoming Accessible,
Culturally Responsive, and
Trauma-Informed Organizations



Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence

A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings