Transcript: Let's Talk about Intimate Partner Violence: Working at the Intersections of Substance Use and Intimate Partner Violence–What Every Provider Needs to Know (Part 3)

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Recorded on September 29, 2022

JEN WINSLOW: Good morning, everyone. We're just going to take a minute to let folks get into the Zoom room, and we will start in just a moment. Welcome, everyone, to today's webinar, Let's Talk About Intimate Partner Violence Part 3-- Working at the Intersections of Substance Use and Intimate Partner Violence-- What Every Provider Needs to Know, with our presenter, Gabriela Zapata-Alma.

This webinar is co-sponsored by the Great Lakes MHTTC and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by SAMHSA under the following cooperative agreements. The opinions expressed in this webinar are the views of the speaker and do not reflect the official position of the Department of Health and Human Services and SAMHSA.

The MHTTC Network believes that words matter, and uses affirming, respectful, and recovery-oriented language in all activities. For more upcoming events and information, please follow the Great Lakes MHTTC on social media or visit our website. A few housekeeping items.

If you are having any technical issues, please individually message me, Jen Winslow, Alyssa Chwala, or Rebecca Buller in the chat section at the bottom of your screen, and we will be happy to assist you. We will be having a period of time for questions near the end. Please put your questions in the Q&A section, and we will do our best to get them answered.

If captions or the live transcript would be helpful, please use your Zoom toolbar near the bottom of your screen to enable by going into the More section, Select Captions, and Show Captions. At the end of this session, you will be automatically redirected to a very brief survey. We'll be very appreciative if you take a moment to fill it out.

Certificates of attendance will be sent out via email to all who attended the session in full. This can take up to two weeks. The recording and presentation materials will be available within the next week on the Great Lakes MHTTC website. And our presenter, Gabriela Zapata-Alma is the associate director of the National Center on Domestic Violence, Trauma, and Mental Health as well as a lecturer at the University of Chicago where they direct the Alcohol and Other Drug counselor training program.

Gabriela brings over 15 years of experience, supporting people impacted by structural and interpersonal violence and their traumatic effects through innovative and evidence-based clinical housing-- clinical housing resource advocacy, peer-led and HIV integrated care programs.

Currently, Gabriela authors best practices, leads national capacity-building efforts, and provides trauma-informed policy consultation to advance health equity and social justice. Welcome, everyone, again, and I will turn it over to you, Gabriela.

GABRIELA ZAPATA-ALMA: Thank you so much. Thanks so much for the invitation to present and share this information. And thanks, everyone, for taking the time to join this morning. I know that when we are busy serving our communities, seeing folks, it can be really hard to carve out that time.

And so I really honor the time that you take away from direct practice and all the things that make direct practice possible. And I hope that we can make the best use of our time together. So in that spirit, please feel free to be entering any questions that come up throughout the session this morning.

Our morning is going to be jam-packed. We have a ton of information and resources in this session, and you'll also be able to find those not only in the slides, but also in the fact sheet that went out this morning. But that said, we absolutely will reserve time for questions. So as things come up, please, please, please go ahead and pop those in the Q&A, and then we will be sure to address as many questions as possible.

So a little bit about my center-- or, it's not my center, but the center that I'm coming from, the National Center on Domestic Violence, Trauma, and Mental Health. We are a national resource center dedicated to the intersection of domestic violence, trauma, mental health, and substance use. We offer training and technical assistance, research and evaluation, policy analysis and development, and we also run some public awareness. We try to raise public awareness around these intersections.

And so here on this slide, you see our integrated framework. And we share this so that you can have an idea of our perspectives, where we're coming from, and that everything we do is really to be rooted within this integrated framework.

So at our core, survivor-defined approaches, meaning that people are the experts on their own lives, that recovery is self-directed, that it comes from within, and that our role really is to meet people where they are, to believe them, to trust them, and to offer relevant resources and support so that we can do our best in being a support. But really, having power with, never power over, people, that everything we do needs to be rooted in relationship and connections, so always using those relational approaches that are dynamic

together, are building of trustworthy connection of being the vehicle of healing and change, that our services are rooted in hope and resilience.

And so here, also thinking about the importance of strengths-based and really hope-centered and that when we're talking about resilience, we are talking about people's amazing capacity to be able to survive and thrive and flourish despite really awful, awful circumstances and situations.

That said, resilience should never be used as an excuse to accept harm or violence or marginalization or poverty, that resilience also means working towards building a world where people don't have to be strong and don't have to be-- that people have the right to tenderness, the right to softness, that we don't always have to be strong and survive in spite of.

And that all of this needs to be built on a felt sense of physical and emotional safety. And that needs to be self-defined, that my sense of safety is not the same as somebody else's sense of safety, especially when we exist in a power dynamic and I'm in a one-up position in that power dynamic as a service provider that I may feel perfectly comfortable and safe in the service I'm offering, but that doesn't mean that the community member that I am working to support also feels that sense of safety.

And so really rooting this in that self-defined sense of safety. So with that at our core, we then seek to integrate domestic and sexual violence advocacy approaches, which are really based in empowerment and in safety as a basic human right. We integrate trauma-informed and healing-centered approaches and approaches that are based in human rights and social justice.

And ultimately, everything we do needs to be responsive to and aware of community, cultural, and historical contexts. Here are goals for this morning. So as a result of being a part of this session, we hope that you'll be able to describe the relationship between substance use, substance use disorders, and intimate partner violence that you'll be able to identify at least four strategies for increasing safe access to substance use disorder treatment, and I will say here really any substance use or mental health service or any resource that a survivor names as being relevant, important, and desired.

And that also you'll come away with some resources and the ability to actively link survivors to anti-violence advocacy services in their community should they desire it. So again, never assuming, never pressuring someone to engage in a service that they're not interested in or that they're not deeming as relevant or safe for them at this time.

So first, thinking about what's the connection. And so reflecting on your own experiences of supporting folks, your own potentially lived experiences, what have you seemed to be the connections between these different experiences, including mental health, domestic violence, sexual assault, substance use and trauma. And I'll be looking to the chat for your thoughts.

What do you see as the connections between these different experiences? And it's perfectly fine to say, I don't know. That's why I'm here. I know they show up a lot together, but I'm not sure. Yes, trauma. Right. We have trauma as a bubble on the screen. But really, trauma is underneath and encompassing all of these.

Yes. We're seeing that echoed trauma. And then-- yeah. Most people I've worked with have experienced all of these. Pain. Yes. Emotional pain, physical pain. Often stigmatized and very difficult for people who are affected by these. Yes. These are all very heavily stigmatized. And then that stigma really gets layered on, so people-- that stigma multiplies as people experience more of these.

And then on top of that, stigma is higher for certain people. For example, for women who use substances, stigma is higher. For people who are pregnant or parenting and are using substances or have a substance use history, stigma is higher. Absolutely. And with that often comes shame. Yes. And then we have here in the chat "life experiences."

Yes. That all of these-- there's a whole lifetime of experience that are often impacted and touching all of these different experiences, that these aren't just things that happen once and then they're over. Yeah. Well, thanks, folks. And keep your ideas coming in the chat. I see one more just came in, emotional or physical experiences that could impact our safety and lead to survival coping.

And thank you so much for sharing that. There are times that people use substances and they don't experience any harms related to that substance use. In fact, the vast majority of people who use alcohol or other substances don't meet criteria for a diagnosable alcohol use disorder or other substance use disorder.

But when we are seeing-- or when someone is experiencing that continued use despite negative consequences, there can be so much stigma there, there can be so many different labels that get put on people. But something that we need to really pay attention to and be aware of is that this person-- there's so many ways that society, and even our fields want to label and say that they're doing something wrong.

And we really need to step out of that and really understand that this person is surviving, that there is something about the substance use, there's something about the way that their mental health is manifesting that is actually, even though it may cause distress and it may lead to problems, that it is an attempt at coping, that there is something protective about it.

And so when we can connect with that and have empathy and really try to see people from their own experience and point of view, that is connection. That's

where a lot of the healing can start, really moving out of that judgment. Thank you so much, folks. So many rich responses.

So I'm going to share some different data that can help shed some more light on this. So first is that we know from research, from lived experience, we know that intimate partner violence has significant mental health and substance use effects in addition to adversely impacting our physical health.

So being abused by an intimate partner is associated with a three-times higher risk for post-traumatic stress disorder, for major depressive disorder, and for engaging in self-injury, sometimes also known as self-harm. That it's associated with a four times higher risk for suicide attempts and a six-times higher risk of developing a diagnosable substance use disorder.

So there's this-- we don't want to say causative relationship, because that requires very specific forms of studies, but what we can say is that it increases the risk, it has a direct impact on the risk for developing conditions related to mental health and substance use. So unsurprisingly, experiences of intimate partner violence are really common in our mental health and substance use treatment settings.

So here on the left, we see in our substance use disorder treatment settings-- and this is particularly on women. A lot of this research has been done with a focus on women. And we know that gender-based violence impacts-- excuse me-- we know that intimate partner violence impacts people of all genders, and we also know that women, including trans women, are disproportionately impacted by intimate partner violence.

And so looking at women in substance use disorder treatment settings, lifetime prevalence of-- and this is usually just looking at physical and sexual abuse-- which we know intimate partner violence is much more than just physical and sexual abuse. But looking at those two, that anywhere from nearly half to 90% have experienced physical or sexual abuse in their lifetime within the context of a romantic relationship.

Now, that's a huge range. That 90% side actually comes from opioid treatment programs. And so also keeping in mind that there's still a lot that we need to learn about the complexity of these intersections. But wherever there is the physical dependence, wherever there there's a potential for physical dependence and withdrawal, there is some evidence suggesting that that then gets weaponized in tactics of power and control and harming survivors.

And so wherever we're seeing that tolerance, that withdrawal, and that physical dependence come into play, we can really see increases in that intimate partner violence. And then just looking at the past 12 months. That was anywhere from a third to 2/3 of women. And that we know that even if someone has been able to-- has decided to and been able to leave an unsafe

relationship, that, many times, the victimization, the stalking, the violence continues.

And this can be in a lot of different places, this can be in drawn-out court cases around protection orders or child custody. This can be ongoing stalking. This can be digital abuse. This can show up in so many different ways. So even if someone isn't specifically in an unsafe relationship at this time, it doesn't mean that they're not continuing to be impacted by intimate partner violence.

And then looking at mental health. We see here about a third of women in outpatient and inpatient mental-health settings. But then when we look at acute psychiatric care, those emergency room settings, those hospitalization and acute hospitalization settings, we see that really jump up anywhere from 30% to 60%.

So we know that intimate partner violence plays a large role not only in the initial development of mental health conditions but also in mental health crisis and precipitating mental health crisis. But many times, as folks were naming in that first piece around the connections, survivors, their experiences of abuse of trauma, of harm, isn't something that necessarily just began in an intimate relationship.

Many times, there is a lifetime of trauma. And so something that we need to keep in mind here are the cumulative effects of trauma not just what-- not just the acute individual trauma that a person may have experienced with a discrete traumatic event. So with adverse childhood experiences, we have the classic ACEs, which are the initial landmark study with-- and these are all adverse childhood experiences that happen within a household.

And so here, we see things listed. Like experiencing physical abuse, sexual abuse, emotional abuse, physical or emotional neglect, things like that. From there, we've also have studies that have looked at the impacts of community-level adverse experiences, things like witnessing community violence, bullying, discrimination, out-of-home foster placements, poverty-- understanding poverty as violence.

And that a lot of times, people have experienced both of these, but there is evidence to suggest that some folks have only experienced adverse community experiences. And so being aware of those is incredibly important. We don't necessarily need to survey or screen for them, but being aware of them as risk factors.

Then from there, also looking at adverse climate experiences. So more and more, understanding that how incredibly connected we are to our environment not just our emotional and household environment or neighborhood environment but the Earth, and that we evolved on the Earth and we-- the Earth is our home.

And so as climate change happens, as more and more natural disasters take place, how we are incredibly connected to and impacted by these. And it doesn't need to be a natural disaster in order to impact us. For example, the pollution, air pollution from factories, for example, being linked to higher rates of asthma.

And so understanding how the climate and our environment plays a role in adversity. And then from there, also understanding the cultural and historical and collective traumatic pieces that we may have endured, legacies of historical trauma that continue to be alive and present today through ongoing policies and practices, things like the overincarceration of people of color, of survivors of color, the criminalization of survival. Understanding that substance use is a health condition-- or can be understood as a health condition, and that, really, what is needed is support, and yet we continue to live in a society that punishes and criminalizes people for something that is really related often to trauma.

So being aware of how survivors and people in general are impacted by ACEs, but the story doesn't stop there. It's also important to be deeply aware of the counter-ACEs, or the positive childhood experiences. And this is an area of growing research. We don't know nearly enough about the protective childhood experiences as we do around the adverse childhood experiences.

But here, there have been four main categories that have been proposed, that is being in nurturing supportive relationships; living, developing, playing, and learning in safe, stable, protective, and equitable environments. So understanding discrimination and inequity and structural violence as a health issue, as a health justice issue, and that equity is at the core of these counter-ACEs.

Having opportunities for constructive social engagement and connectedness, and then learning social and emotional competencies. And then, of course, trauma prevention and protective factors-- social support, positive connection with a caregiver has a lifelong protective effect, socioeconomic stability, and access to medical and mental health care.

And when we say access, we mean access. We mean real access. That does not mean I have a super high deductible and can't access mental health care because of my deductible. That does not mean, I'm ready for a substance use disorder treatment, but there's no treatment providers in my area or there's no treatment providers who are accessible for people who are pregnant or people with small children.

So there's that-- when we talk about access, it really is true and meaningful access that is timely and is relevant for the person in their situation. So we have all this data around these intersections, but what is less well-recognized

are all the ways that people who abuse their partners engage in coercive tactics that target a partner's mental health or use of substances.

So this is looking at how mental health and IPV or substance use and IPV actually combine together to create a really unique dynamic that we refer to as either mental health coercion or substance use coercion.

So this form of coercion, it includes a range of abusive tactics that ultimately are designed to undermine a survivor's sanity and sobriety, to control a survivor's access to treatment and other resources that aid in their well-being and their stability, that tactics that are designed to sabotage a person's recovery efforts, that are designed to discredit a person with any potential sources of protection and support.

And this often also includes jeopardizing child custody. So it's intergenerational as well. So it's jeopardizing the survivor and really harming a survivor but then also working to harm and jeopardize the survivor's children as well, because we know that what's most protective for children is to have that attachment to the protective caregiver.

And these abusive tactics are designed to exploit a person's mental health or substance use for their personal gain or their financial gain. So here, I'm going to share some data that came from the first large-scale quantitative study on substance use coercion and mental health coercion that we conducted in partnership with the National Domestic Violence Hotline.

So on the substance use side, the study spoke with over 3,000 callers. The callers were just not in time of crisis the time of their call, and consented to being a part of the survey-styled study. Nobody was prescreened for substance use, for mental health. There was no prescreening. So these were just general callers.

So of those general callers, 26% have used substances to deal with the emotional or the physical pain of intimate partner violence. 27% have been pressured or forced to use substances or made to use more than they wanted. So even if they were already using substances, even if, let's say, they were already using alcohol, they were pressured or forced to drink more alcohol than they wanted in an attempt to harm them or to exert power and control over them.

24% were afraid to call the police because their partner said that they would be arrested or they would be not-- they would not be believed. And this is something that we hear time and time again from survivors and from advocates, is that people try to call the police to get some kind of assistance, and then the abusive partner is able to convince police that, no, this person's just drunk or this person doesn't know what they're talking about or they're high, they're out of control. I had to restrain them.

And then because of the stigma of substance use, the survivor is not believed, and then is actually left in a much more dangerous situation because now they've tried to get help but not been able to get any protection from that home, which increases the danger from the person who's trying to harm them.

And then 38% said that their partner had threatened to report their substance use to authorities to prevent them from getting something they wanted or needed. Now, most commonly, these were things like preventing them from getting an order of protection, preventing them from being able to get custody of their children or maintain custody of their children.

This also includes threats to call Child Protective Services, threats to employers to try to jeopardize that person's job. We know that, very often, economic stability is a huge protective factor when it comes to intimate partner violence. And so financial abuse and jeopardizing income and employment is going to be one of the main tactics in order to really entrap survivors.

I know that when I was a supportive housing provider, I would get phone calls all the time trying to get survivors in the program kicked out of my program, trying to jeopardize their housing. And most often, that was calls to me as the director of that housing program saying, well, so-and-so was just using drugs, and you should kick them out.

And thankfully, not only were we a housing first-based provider and a harm reduction-based provider-- so that didn't fly. But on top of it, being aware of the dynamics of intimate partner violence would then also clue us into what was happening and not let that person manipulate us to then cause harm towards that survivor. Instead, we were able to really protect the survivor's confidentiality, anonymity, of course, the famous, I can neither confirm nor deny, [? clique ?] but then also, be able to offer supports that felt relevant, helpful, and safe for the survivor in our program.

Now, on the mental-health side of that study, what we learned was that four in five callers said that a partner accused them of being, quote unquote, "crazy." And then three in four callers-- the partner deliberately did things to make them feel like they were losing their mind. So this is-- all goes into gaslighting. Very, very common. And then 50% of callers, one in two, said that their partner threatened to report, that they were, quote unquote, "crazy" to keep them from getting something that they wanted or they needed.

And again, this was very often in order of protection or custody of their children. And we have gone as far as to do analysis of child custody cases. And what our analysis has found time and time again is that when an abusive partner raises mental health and substance use concerns in a child custody case that then that does influence the court to assign custody to the abusive partner.

And that is complete-- not only is it unjust, but it is completely detrimental to the well-being and the mental health of children. And so as mental health providers, substance use providers, peer supports, as helping professionals, we have a role to play in really supporting survivors and their children from this form of abuse.

This same study also found that when people tried to get any kind of help-- so when they try to reach out to mental-health supports, when they try to take psychiatric medication, when they try to reach out to substance use supports or access medication recovery, medication-assisted recovery, or go to a 12-Step meeting or another kind of recovery support meeting-- that their attempts to get help were then sabotaged.

So on the mental health side, it was one in two who had tried to get some kind of help were actively discouraged or prevented. And on the substance-use side, it was 60% of people who had tried to get help. So understanding how this form of abuse directly-- not only uses mental health and substance use to denigrate abuse, harm, and isolate survivors, but then goes as far as to prevent them from getting any kind of help.

So this is from the qualitative part of that same study. We really wanted to hear from survivors in their own words. And so I'm going to read this out loud, and I'm going to ask folks to listen for substance use coercion. And when you notice any substance use coercion, go ahead and write in the chat where you're noticing those coercive tactics.

"He threatened countless times to call the sheriff and the pastors and report my drinking. He discouraged me from getting help from my drinking. After I got help for drinking, if/when I drank again, he would say, "See, you failed at this too. He would leave bottles all around when I was in recovery."

So we'll give folks a moment just to take this in. Yes. The leaving the bottles around. Yes. That actively trying to risk to precipitate a setback in that person's recovery goal. Absolutely. Emphasis on the word "threatened countless times." Yes. And threatened to report to authorities, and threatened to report to potential sources of safety.

So if that person wants to try to get any kind of legal protections, then this the abuse of partner is threatening to discredit them. And also, studies have found that when people are connected to a faith community, that, many times, a faith leader is the first person that they'll reach out to for help.

And so threatening to tell the pastors. Again, cutting off from that source of support and protection. And I see here people really picking up on the "failed." "You failed at this too," the reminder of past mistakes or setbacks. And all of that-- really, that discouragement and that denigration and that shaming.

Discouraged from getting help. Yes. And taking away that person's power and control, absolutely, which, what we know about substance use is that shame. And shame really drives substance use that isn't aligned with somebody's goals. It gives them something to try to soothe, to try to cope with.

And so really trying to turn up the emotional pain in order to keep that person in a pattern of substance use that is harmful, that they do not want, and that will help maintain control over them. Right. Thanks, everyone. So here, we've talked about a lot of this, so I'm going to pick up the pace and go a little quickly here.

But you have this in the slides along with the citations in case you want to revisit any of these. So survivors are often introduced to substances by an intimate partner. And if were already using substances, then, many times, are introduced to a new substance, a substance that then can be used to better exert power and control over them.

So potentially, they were using cannabis, and then they're introduced to methamphetamines or opioids in an attempt to try to really increase that power and control over them. And the intimate partner plays a really large role in moving from that initial use to developing problems related to that use, including physical dependence and withdrawal.

And then the abuse really-- so it begins, initiates that potential use, moves it to the point of a problem, and then sabotages any access to help, things like not being allowed to attend meetings or treatment, withholding resources that people need in order to access these kinds of supports, the keeping of substances in the home.

And then with medication-assisted recovery, there's a whole host of abusive tactics and attempts at victimization that come into play. So that is a life-saving intervention and absolutely often requires some safety planning to be able to access it for folks who are in need of medication-assisted recovery.

We already talked about the provoking of relapse as a tactic of abuse. And so one thing I'll note here is that it's not only exposure to substances or things like keeping bottles around, like we heard from that one survivor, it's also exposure to stressful experiences because we know that those unwanted emotional pain, guilt, shame, or the interpersonal rifts, that interpersonal conflict, that all of those act as craving cues, or sometimes called triggers, for a return to use in a way that isn't aligned with that person's recovery goal.

And so even just picking a fight or literally even just abusing a survivor so that then they feel that pain and then return to that substance use in a way that is counter to their goal and to their safety. Something else to note here is that women, because of some differences in neurobiology, women tend to experience stronger cravings-- and that's associated with increased risk of a return to-- I'll say a setback in a recovery goal.

And so any program that is cutting off resources or support because of a return to use is inaccessible for a survivor and is really not taking into account the gender-specific needs of women, but also not taking into account the realities of substance use coercion. And then the substances get used to entrap survivors in unsafe relationships or draw them back into unsafe relationships.

So this is done in so many different ways. A couple that I'll highlight is the threat of withdrawal in order to trap survivors. And we see this especially when an abusive partner has ties to where-- the network where a survivor may be able to access substances. So for example, having heard from survivors that they had attempted to leave an abusive partner but then they were still dealing with withdrawal and weren't able to access withdrawal management services.

And when they tried to get substances on their own to just cope with the withdrawal-- remembering that withdrawal can be life threatening with some substances, that they couldn't get it from anywhere. Specifically, a survivor once shared with me, It's like I had been marked as his property and I had to go back to him to just not deal with the withdrawal.

So then thinking about how the fact that treatment is so inaccessible in so many of our communities, that how that then plays right into the abuse and keeping people entrapped in relationships. And then once that control is in place over the withdrawal and the access to substances, then that very quickly can be used to force survivors into illegal activities.

And sometimes that also includes things like human trafficking. So being aware of that as well. And then any substance use history then, including our own treatment records, our own provider records, then get subpoenaed and attempted to be used against survivors in any kind of legal matter. And this has only increased since the pandemic.

And so we talked about-- we talked about this piece, that it's very common to try to jeopardize that parent-child attachment when that parent-child attachment with the protective caregiver is something that is most indicative and central to children's well-being.

So now that we have really shed a light on a lot of these complex connections between these experiences, I want to open the floor and invite folks to name in the chat-- of course, while guarding any confidentiality-- that name in the chat, what are some of the tactics of mental health coercion or substance use coercion that you've noticed coming up amongst folks who access your services?

And this is so that we can learn from one another and we can really widen our perspective and be able to recognize it when it's coming up because without

this awareness, what ends up happening all too often is that survivors get blamed for the abusive tactics that they're experiencing, and their access gets cut off from our services or they get misserved by our services.

So here, we are just summarizing the complexity of the control tactics with mental health coercion and substance use coercion. And a piece that I will just highlight-- and hopefully you can see my cursor-- is the way that then all of this gets used in our systems to really harm and leverage our systems against survivors.

And while people who cause harm, people who exert power and control over survivors, they're accountable for their own behavior. And by that same token, we as service providers are accountable to eradicating stigma in our services and in our systems because anywhere where there is stigma against mental health, substance use, and trauma, and IPV, anywhere where there's stigma and discrimination and lack of access for folks, that is a wide-open door for us to be manipulated and then leveraged against survivors.

So this-- so-- oh no. OK. Well, PowerPoint experienced a problem. So it's now relaunching. Looking at the chat. Yes. Using immigration status as a tool of power and control. Yes. 100%. And then absolutely with LGBTQ+ folks, really that threatening to tell, to disclose that personal information because we know that there's still so much widespread discrimination.

And so being able to threaten the disclosure of one's identity to-- when one is out yet or maybe one is out in certain spheres but not in other spheres, using that, absolutely, to exert power and control. And so the thing to remember here is that anywhere where there is discrimination, anywhere where there is societal or structural violence or harm, that becomes a place that then becomes a tactic of abuse because abuse is about power and control and is about oppression. That's what abuse is about.

It's not about, I got angry and couldn't control my anger. That is not what it's about. Abuse is about power and control and oppression. So anywhere where there is stigma or discrimination or structural violence, that then gets weaponized in abuse. Absolutely.

And so understanding that structural violence and interpersonal violence are linked and that we cannot end interpersonal violence until we also address systemic and structural violence. And so there's a lot of plays-- a lot of ways at this plays out, the ways that Javier said in the chat. Absolutely.

Some other ways that this plays out is, for example, people of color are more likely to have access to treatment through criminalization than through wanting treatment, recognizing a need for treatment, and then being able to access it. And there are studies that suggest that people of color actually-- so often with substance use we talk about, well, people aren't ready for it or people don't recognize they need it.

And when we have actually looked at some racial and ethnic differences in that idea, it's actually been found that people of color have higher rates of recognizing that they are in need of treatment. But the issue is the lack of access, not the lack of insight.

And so when we think about all of the ways that historical and collective trauma and structural violence criminalizes people of color who use substances and then we add that in to the way that that impacts access to substance use disorder care that is even accessible-- and then on top of that, is culturally affirming culturally responsive.

And then we add on top of that the layer of now substance use coercion and being able to then jeopardize any little access that that person may have had, that survivor of color may have had to have treatment resource. So understanding that intersectionality of structural violence and interpersonal violence and how they really potentiate one another and hook right into one another.

So given all of this, given all of this, what can we do to enhance safety and recovery for survivors? So everything that I'm going to go over here comes from-- or I should say 95% of what I'm going to go over here comes from this toolkit. As a National Resource Center, everything that we do is available for free on our website.

So this toolkit is specifically designed for primary care and behavioral health settings. That said, it has tools that can be used in virtually any setting, including DV settings, including recovery support settings. There's really a lot a lot of tools here that can be used across settings.

So here, I am just going to give you a taste of each of these different pieces. But at the same time, knowing that you have this resource to really take a deeper dive. So the first thing we want to do is we want to focus on setting the foundation for being able to safely and adequately respond to survivor's needs.

So first of all, universal training on intimate partner violence and mental health and substance use coercion. Just straight up universal training. And also, all of this is going to build on accessible, culturally responsive, and trauma-informed services. Sometimes people have the question, well, if my services are already trauma-informed-- which I would say is a journey, not a destination-- but if my services are already trauma-informed, aren't they already safe and accessible for survivors of domestic violence?

Usually, it's not enough. Usually, the tenets of trauma-informed approaches don't effectively prepare us for safely supporting survivors. But it is the foundation. We do build on that.

Centering survivors' self-defined goals and concerns. So anywhere where our program is prescriptive, anywhere where our program is trying to be persuading, convincing, trying to steer the boat, that is going-- that has the potential for being retraumatizing and revictimizing for survivors because survivors already are subject to all of that power and control over them, and the healing is about empowerment and power with. That's where the healing is. That we develop relationships with our local anti-violence advocacy programs, our local domestic violence, and sexual violence advocacy programs.

That we attend to safety and confidentiality. So attending to all of those safety needs and understanding confidentiality is a safety need. And that in order to do all of this, we need a culture of staff support and community care. We can't just layer things and layer things on top of staff, layering all the demands on top of staff and think that staff can just absorb new ways of doing things and best practices without their own support and that own culture of team support and community care.

Here, there's a continuum of responsiveness, from non-responsive-- which is not on the continuum. But then the first spot on the continuum is programs that are informed. These are programs that are aware of the dynamics of intimate partner violence, mental health, and substance use, including coercion related to mental health and substance use.

So some of the common approaches that we see here are things like cross-training, interdisciplinary teams, referral partnerships. From there, we move to a midpoint-- collaborative programs. Here, we see active collaboration across the field. So here, some of the common things that we see that have been very successful are cofacilitated groups in both settings.

So for example, someone from a mental health practice is partnering with a DV advocate from the local DV organization and you're getting together. And maybe in the mental health program, you are cofacilitating a group on healthy relationships. And then in the DV program, you're cofacilitatomg a group on, let's say, emotional safety planning.

And so that way, folks have some initial access to that expertise, to the services. And then they have a really natural bridge when and if they choose to engage in that more specific service. We start building that trust that way not only with community members within a program but also amongst programs.

And that is really key because what we start seeing there is that now we are building that community of care and now we have somebody who we trust, who gets the dynamics of intimate partner violence, who, that when there's maybe a mental health crisis happening in the DV program, you now have someone who you can trust and you can call up and say, hey, this happened,

or this is happening and we've tried this, what else can we do, and that that improves services across the spectrum.

And then we have on the far end, full integration of services. So this is full integration in every service we offer, but it's still survivor-defined and survivor-led. So it's a menu of services offered across programming that are provided based on the survivor's self-defined needs.

So here, we often hear things like No Wrong Door approach or also people say Only Right Door approaches, that whatever door you open, it's going to be the right door for you. Now, some key elements when it comes to clinical and peer support services. To be able to have routine conversation around IPV, to validate and affirm survivors while also recognizing the impact of abuse and trauma, to be prepared to address immediate and ongoing safety needs using collaborative methods.

That we're not here to tell anyone, this is how you stay safe. Know that we collaborate with people in their self-defined safety. So that's the partnership piece. Then being able to link to those local advocacy services, and then ultimately using approaches that are evidence based for survivors.

So in moving beyond screening, we often talk about moving beyond screening because screening comes from a medical model where, often, what we do is we ask some yes or no questions. If it's no, we leave it alone, we're done. If it's yes, then it implicates a set of actions to be taken.

And it ends up being somewhat of a simplistic and a top-down approach that isn't responsive to the realities of survivors. So what we talk about instead is building the safety for conversations around intimate partner violence to emerge, building opportunities and safety for survivors to be able to just tell us what is going on with them in their lives.

And what's really beautiful is that when people have that false sense of safety, it's like they just needed that moment and they can't wait to finally have a safe person and a safe moment to be able to talk about what's going on. And so we're really going to focus on building that safety.

But I know we have a lot of experience in this virtual room, so I invite folks to put in the chat, how are ways that you build safety for survivors to be able to talk with us? So think about that. Share what-- the great things that you're doing. And then I'm going to just throw out there some of the core elements.

So understanding that any time a survivor shares something with us, that can increase their risk, that there can be a lot of retaliation when survivors talk about the abuse that they're encountering. And so this is part of the reason why, many times, people just aren't able to share what's going on in their relationship. So one thing that can be really important here is to cultivate

access to resources that people can access without having to tell us that they're experiencing violence and/or abuse in their relationship.

So this can be things like, if we have a resource board, having those different advocacy resources up, those can be things like having discrete resources that people could take a phone number, having a little business card size resources that people could pocket discretely, having resources in the bathroom, on the inside of the stall where people could grab a number or use a QR code to pull up something and then maybe save a hotline number under a different name in their phone. Things like that.

Or be able to start texting a hotline from the bathroom. So all the different ways, making it as accessible as possible. If folks are in a tele environment and don't have the opportunity to have those visuals in their space, then what some programs have done is prepare a resource packet that people can take with them or that gets sent and shared with the person, with their permission, of course.

And that then, advocacy resources are nestled within a ton of other resources. So it's like a rental assistance and food and children's resources and maybe some community building resources, and then also the advocacy resource, and it's there in a way that is nestled in and discrete. And that this also requires our staff-- our staff to be savvy and knowledgeable not only about intimate partner violence but then the resources that exist.

Treating confidentiality as a safety need. So a lot of this is best practices as part of our informed consent anyways. So some things to highlight here that are particularly important are options for protecting information, thinking about things like electronic health records, explanation of benefits, where are they getting mailed, billing and referrals.

For example, there have been-- with the new insurance lookup systems using people's identifying information like Social Security numbers, date of birth, things like that, there absolutely have been situations where a survivor is able to escape with a child and then enrolls a child in a health care that is billing insurance and then that unsafe ex-partner who shares that child puts the child on their insurance.

And then when the clinic doesn't bill the insurance that the survivor provided but instead does a Social Security number lookup and starts billing the insurance that is actually connected to the ex-partner, and then the ex-partner receiving those explanation of benefits and being able to then locate a place that a survivor goes and is able to locate and then stalk and potentially victimize there.

So this requires really looking at our privacy practices through a wholly different lens and looking at what are all of those gaps that we need to plug up in our system in order to really increase safety. And this includes things--

safety and teleservices, as well. And that's something that we have some information on, how to not only telehealth platforms but also how to safety plan around the use of telehealth to really address the likelihood of digital abuse.

And something that is really key here is that flexibility and service times and locations, that every survivor's situation is going to be different and is likely going to change. Where, maybe this week, telehealth is the safest thing. But next week, because, let's say, the unsafe partner is home from work next week and there's no safety at home to do the session and having an excuse to get out of the house this coming week is actually a lot safer. So the next week, we're going to do in person. So having that flexibility is key.

And then our documentation. So thinking about documenting to protect survivors while knowing that, many times, we are serving survivors and we don't know it yet. We don't know it yet. Many times, we don't learn about the abuse that someone is experiencing until there has been a crisis or until some time has passed and that person has been able to build that felt sense of safety with us-- or we've successfully been able to build it with them may be the more accurate way to say it. And then they can talk with us about it.

So there's a lot more here that's available in the toolkit. But some things to keep in mind is that any information that becomes available to an abusive partner can increase that person's danger. So for example, having heard from a psychiatrist colleague who shared with us that every time that a survivor shares with her what that they're experiencing, IPV, one of the things that she does in that moment is offer to look at the electronic health record together to update records.

And then also set the permissions and change the settings in the electronic health record so that the person doesn't have emails coming to their electronic health records saying, you have a new note, so the person doesn't have the electronic health record app on their phone because of how often people who are experiencing mental health and substance use coercion are having their email monitored and then being forced to open up the electronic health record with that abusive partner and then facing danger when they see that the clinical note has noted any kind of intimate partner violence.

So requires us to really be engaged and be thinking through all of these pieces. Knowing that records can be subpoenaed and that thoughtful documentation of IPV and its effects can help survivors if they do want to be able to use their clinical records to substantiate their claims.

A lot of times, survivors will have their mental health and substance use histories raised in court in order to discredit them. And unfortunately, it works. That's why abusive partners do it, because it works. And so our records can actually help bolster their credibility and help counteract that form of coercion in the courtroom.

So if we are ever documenting symptoms around mental health and substance use, then we also want to be including the connections between the symptoms and the abuse, if and how if the abuse the abuse creates any barriers to participation in services. Think about this. So often in child welfare determinations, they'll look at how engaged someone is in a service.

Well, if someone hasn't been able to be engaged because their treatment is being sabotaged, how is that being reflected in the record so that this survivor isn't just again being revictimized because of this abuse? Then we also want to be sure to document a survivor's effort to protect and care for their children.

Ooh. Time is just slipping through my hands. So I'm going to go over some things pretty quickly. So here, before we ever open conversation around potential intimate partner violence, we need to ensure privacy. And so we want to ask to speak privately. If a person declines, do not insist.

Just say, OK. No problem. And save your questions for another time because the last thing we want to do is make it so that person then doesn't have access to our service because if we insisted on a partner leaving the room, and then that person is either subject to greater abuse or power and control after that appointment.

So we just want to go with it and then try to build in opportunities to have those private conversations. If we are able to have private conversation, then here's are some conversation openers. For substance use coercion, here's one that I particularly like. Sometimes people have been hurt by a partner find themselves using substances to deal with the pain. This is a pretty common reaction. If this is something you can relate to, know that we're here to support you.

So it doesn't even put people on the spot, really just provide some information, and that allows for some space for the person to share about coming up for them. Here are a couple of questions that can be particularly helpful around some of the economic abuse, some of the ways that a partner's use may impact the survivor's use, as well as some of that overlap with potential human trafficking.

All right. So I'm going to skip forward a little bit just because of time. Some things we want to listen for substance use coercion is self-medication, coerced use, manipulation using substances, the undermining based on a person's substance use history, blaming them, blaming the abuse on the substances, threatening them-- threatening that they'll lose custody of their children because of their substance use.

And then, of course, anything around coercion until illegal activities, inducing fear, and sabotaging of recovery efforts. And we do want to ask about the children if there are children. We want to ask about if there are any threats to

leverage child protective systems or proceedings against them. Very common tactic of abuse.

Or threats around disclosing any of their mental health or substance use to children or to other trusted supports. Ooh. I'm going to skip the scenario, unfortunately, just because of time. But it is here in the slides if it's something that you want to use to practice or in any of your team meetings.

So here is a brief intervention in person-centered services to support safety and safe access to services. So if someone shares with us that they are experiencing substance use coercion or mental health coercion, it's incredibly important to first respond with validation and affirmation. We don't want to jump to problem solving.

So just responding with how this is not their fault and how we believe them and we're here to support them. Then it's important to ask permission. Before we offer resources or ask more follow-up questions, let's check in with the person.

Have them consent-- or not have them consent, but ensure that you have their consent before going deeper into this because the last thing we want to do is leave this person feeling like they've totally lost control over the conversation or that now they have to talk about this thing when, actually, they were really hoping to focus on this other thing today because it's a more pressing need. So check in with folks. Ask permission. And respect the no.

If someone says no, thank them for letting them know that they really want to focus on something else right now. So it's really important to have consent through all of this. If they do consent to talking more about this, then we want to offer some strengths-based support and some emotional support.

Things like, what are some of the ways that you get through this? Who's there for you in all of this? What are some ways that you protect yourself and your children? And then offer to talk about some safety strategies and resources if that would help. So here, some things that you want to focus in on is safety planning around their access to your mental health or substance use or other supportive service.

So things like safe strategies for keeping appointments, for staying connected to services if they're pressured to leave, safe contact, safe options for contact, how to maintain control of their medications, whether they need more flexible or staggered appointments, and then any legal documentation that may enable an abusive partner to have more control over them.

So for example, when I was working with folks who were receiving disability benefits, it was pretty common for somebody's representative payee to also be somebody who was exerting power and control over them, so being aware of those things.

Or, for example, in a psychiatric advance directive, do they want to ensure that this person does not have control or a right to influence or even know about any of their acute mental health care in the case of that they're not able to make their own mental health care decisions in that moment?

And then we want to link to any desired resources. Advocates are experienced in all of this and have so much support to offer, including advocating across complex systems, crisis support, locating needed services, and IPV-specific counseling-- so counseling that can really focus on safety planning and the trauma of IPV for survivors and their children.

So here, we have the national hotlines. But then, of course, knowing your local hotlines as well can be important. And the thing to never ever do is to never advise or try to persuade a survivor to leave a relationship. It's not helpful, and it's downright dangerous. The times that a survivor is at greatest risk for being killed by a partner or ex-partner is when they're pregnant and when they are attempting to leave or have just left a relationship.

So we want to do the opposite. We want to say, no matter what relationship you're in, this one, another one, no relationship, we are here to support you. So really, we want to take all the pressure off and really, really make it clear that we're here to support them unconditionally, regardless of whether they're in that relationship or not.

And what I just described, that conversation opener to recognizing the common forms to that brief intervention and then connection to services, we have a substance use coercion palm card and a mental health coercion palm card that can help you-- it's like a cheat sheet-- can help guide that conversation while you're getting used to it.

So here's the one on substance use coercion and then the one on mental health coercion. And these are all active links in the PDF. So we are getting close to our Q&A time, so I'm really going to speed it up here and just point out a couple of things. So there are studies that have shown that integrated care for mental health and IPV or substance use and IPV is uniquely beneficial.

And so we don't want to segment care. We don't want to take any kind of sequential approach to care. We really want to integrate awareness of mental health and substance use coercion into what we're doing. And so our systematic review, we found that there were five elements that can be added to existing evidence-based practices that you're already using in order to enhance their effectiveness for survivors.

So one is adding information about the causes and the consequences of intimate partner violence and the traumatic effects of IPV. Two, awareness of mental health and substance use coercion and the attempts at sabotaging

recovery efforts. Three, attention to ongoing safety. Four, cognitive and emotional coping skill development to address trauma-related symptoms and support people in their goals.

And fifth, a focus on survivors' strengths, including cultural strengths on which they can draw. So you can really-- you can focus these five elements and building them into what you're already doing to enhance effectiveness for survivors. We have IPV-specific trauma intervention repositories.

So we looked at models that have been tested with survivors and really analyze their results, who they were helpful for, what the goals that were, how they were measured, all that good stuff because the reality is that survivors historically have been excluded from research. So we wanted to be sure to zero in on the evidence that does exist.

For anyone who may be interested in using any kind of community recovery group, such as 12-Step, Smart Recovery, Women for Sobriety, it's important to never mandate or pressure participation. But if a survivor is interested to support a survivor with safety planning, as well as support a survivor and being able to bridge any concepts that might be hard to take in as a survivor-- because sometimes, the concepts aren't necessarily-- they aren't necessarily compatible or trauma-informed sometimes. So here are some resources that can help there.

And then, of course, a focus on recovery capital. Structural and interpersonal violence really interrupt people's access to internal and external resources that people often need and use in their journey of recovery. And so looking at, how am I supporting recovery capital and what's missing from this picture and how can I really enhance my services to help address some of those gaps in recovery capital.

So in all of this, let us be sure to not forget our traditions, our relationships, our beliefs, and culture as sources of support, healing, and resilience because where trauma breaks meaning, culture makes meaning. And with that, I'm just going to click through some of the different resources we have as we get ready for questions and answers. So if there are any questions, I'm happy to go ahead. We can go ahead and start.

JEN WINSLOW: Great. We have two questions in the Q&A section at the moment. The first question is, would you see the threat of prison for abortions as structural violence?

GABRIELA ZAPATA-ALMA: Yes, absolutely. Yes. We know that it's absolutely structural violence. It disproportionately impacts people who experience a lot of other forms of structural violence as well. And also, at the intersection with intimate partner violence, there is a form of abuse known as reproductive coercion which is where survivors' birth control methods or

reproductive health methods are actively sabotaged in an attempt to coerce them into pregnancy.

And so in the reality of reproductive coercion, it's even more dangerous for survivors. Yes. Absolutely.

JEN WINSLOW: Thank you. The next question is, are there any current DV programs that utilize peer support?

GABRIELA ZAPATA-ALMA: There are. There are. This is a growing-- oh my gosh. I love peer support. The movements are incredible. And there's a growing number of DV programs that are formally employing folks with lived experience, lived experience of intimate partner violence as well as lived experience of mental health and substance use recovery and trauma recovery.

And it looks different. In the programs that are doing it, it looks really different. There are some programs that are focusing on peer support programs where-- or, I should say-- yeah, peer support programs within their program that are focused on hiring people who have experienced not only intimate partner violence but substance use coercion and child welfare involvement as part of the abuse that they faced in substance use coercion.

And then supporting them to get trained as recovery coaches as well as DV advocates and then providing peer-based services. It is such an amazing space for vitalization in our field. It's such a huge, huge place for just all the things that we want, all the positive things you'll want to see, the power with people and the healing.

I mean, it's just-- it's an incredible area of growth in the DV field and a great place for collaboration across the DV field as well as mental health and substance use fields. And so absolutely. There's a lot of room for growth there, and there's so much to be gained.

JEN WINSLOW: Thank you. And one more question right now-- Oh, another one just came in. But, what can you say to someone experiencing domestic violence and have normalized the behavior?

GABRIELA ZAPATA-ALMA: It really depends on the situation. It depends on where that person is at in their process and it depends on where they are in their moment, really. There are times where we may want to-- we may want to say with every cell of our body, this is not normal.

But it wouldn't actually be helpful in that moment, and that person might actually come away feeling judged or feeling like we're someone who they can't talk about with this-- talk about this with. So there are times where, really, the right thing in that moment is to respond with compassion, with

empathy, to respond with some curiosity like, where did you first hear about this or experience this?

Like, where did this-- where did this first start feeling normal? And then there are times where we respond with just that gentle affirmation, that gentle validation where we may say something along the lines of, this is something that you've been dealing with in your day-to-day for a long time. And I also want to be here and say that you deserve to be treated with dignity and with respect.

You have a right to safety. There may be other times, depending on our relationship, on our connection, on where we're at in that pers-- with that person in our-- in the time-- the conversations we've already had together, that trust might be super built up or we might say, part of the way that this kind of violence works is that it makes itself seem normal, but it's absolutely not.

Would it be helpful to look at some of the different ways that power and control tries to normalize itself, has a way of disguising itself? Would it be helpful to look at the power and control wheel? Would it be helpful to look at the healthy relationships wheel? So it really is going to depend on where that person's at and meeting them where they are.

JEN WINSLOW: Next question says, I would like to know how to, as part of advocacy for victims, to include perpetrator services. I see too often that there is a lack of accountability in criminal civil justice system for perpetrators.

GABRIELA ZAPATA-ALMA: Yes. I have worked with people who cause harm as a therapist. I have not ever worked in a specific Battering Intervention Program, often called BIPs. So I can't speak from my own personal work experience in that way.

But what I have found is that our systems of accessing BIPs are heavily, heavily tied to legal systems, and I have met many, many people who have caused harm and wanted to access specialized services around it and not been able to because they haven't been able to afford it or they've only encountered programs that were accessible if they were mandated to it not out of their own volition.

So we have a ways to go when it comes to having a system that really goes to-- that really is accessible and effective for people who cause harm to be accountable for their behavior and to no longer cause harm. And that that accountability, many times, the historically the focus has been on external accountability.

And that we know that change comes from within. And so I would say that the more innovative BIP programs that I've seen have really focused on that internal accountability. So that even if the person is getting there from an

external accountability, once they're in the program, the focus becomes the internal accountability.

But for example, there are other countries who have a hotline for people who are causing harm in their relationship and want help. There's a hotline that they can call and that they can access help. Something as simple as that I think would be really groundbreaking in this country.

And so there's, I think, a lot of space, a lot of room for growth in how we create systems of accountability that actually are effective and are accessible because, ultimately, we need to be looking at stopping the violence, not just surviving the violence.

JEN WINSLOW: That was the last question.

GABRIELA ZAPATA-ALMA: All right, folks. I want to say thank you so much, and I will turn it back to y'all.

JEN WINSLOW: Thank you so much, everyone, for being here. And thank you, Gabriela, for a wonderful presentation. I know we've all learned so much. We have another presentation with Gabriela in just a few days. Next Tuesday, October 4. I just put it in the chat, the link to the registration.

We have that one and then one more to round out this series on intimate partner violence. As a reminder, the recording and the transcript and presentation materials will be on our Great Lakes MHTTC website within the next week. You will receive your certificates of attendance via email within the next two weeks.

Please check your spam and junk folder. Sometimes they can land there. And as we said before, you will be redirected to a short survey as soon as we close out this webinar. And we greatly appreciate you taking it. It allows us to continue to provide free trainings to you all. So thanks again. Thanks, Gabriela. And we hope to see you next week. Bye-bye.