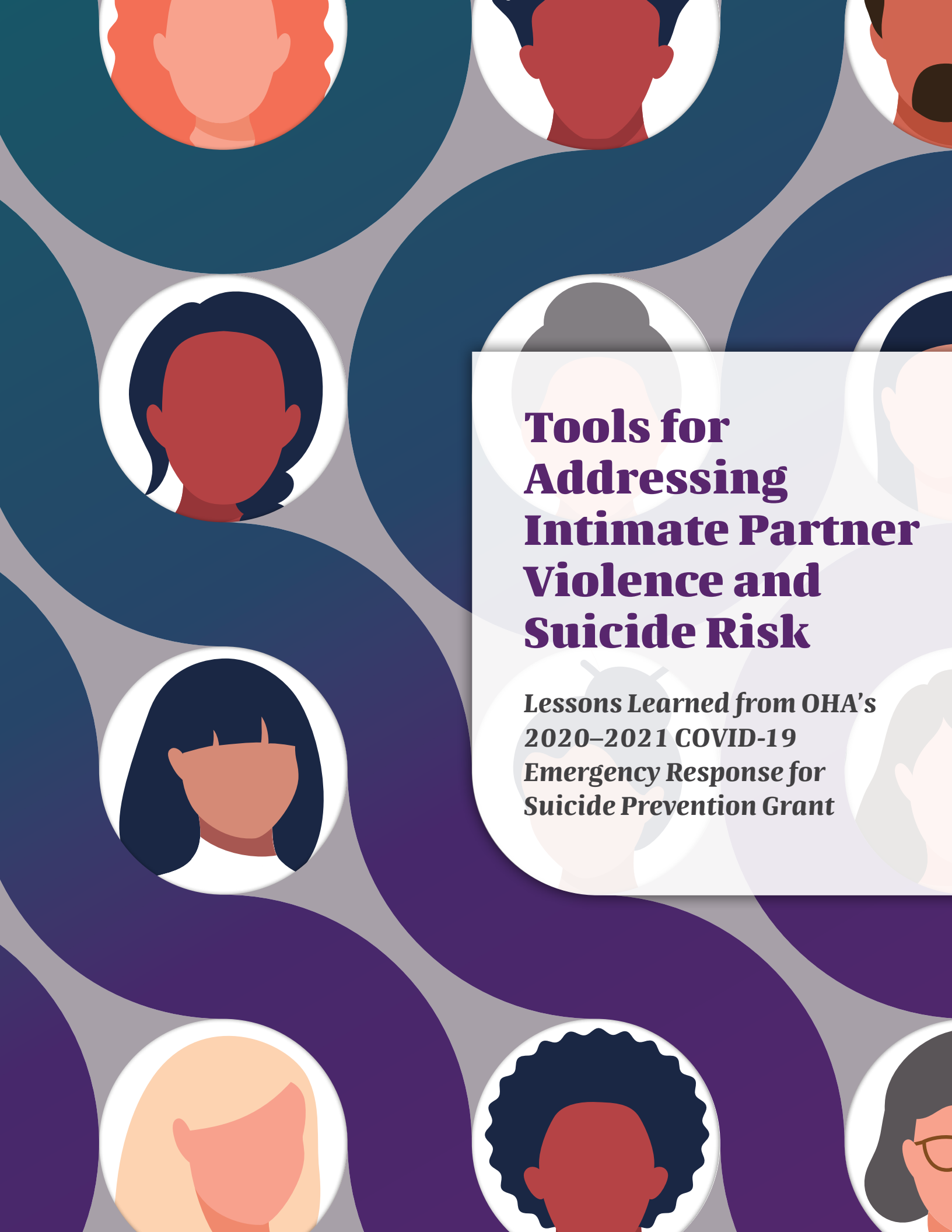

Tools for Addressing Intimate Partner Violence and Suicide Risk

Lessons Learned from OHA's 2020–2021 COVID-19 Emergency Response for Suicide Prevention Grant

Tools for Addressing Intimate Partner Violence and Suicide Risk

Lessons Learned from OHA's 2020–2021 COVID-19 Emergency Response for Suicide Prevention Grant

Background

In August 2020, the Oregon Coalition Against Domestic and Sexual Violence (OCADSV), the Oregon Health Authority (OHA), and Portland State University's Regional Research Institute for Human Services (PSU RRI) began an 18-month collaboration to strengthen support for domestic violence and mental health agencies during COVID-19. As part of this grant, six domestic violence advocacy organizations around Oregon were able to place co-located advocates with their mental health partner agencies for services and cross-training. The content of this booklet is another product of this collaboration.

Suggested Citation

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SAMHSA
Substance Abuse and Mental Health Services Administration

About OCADSV

The Oregon Coalition Against Domestic and Sexual Violence (OCADSV) is a non-profit, feminist organization founded in 1978. The member programs that serve survivors of domestic and sexual violence in communities across the state comprise the core of the Coalition. The Coalition provides training and technical assistance to crisis centers, engages in systems advocacy, and supports multi-disciplinary efforts to develop effective agency practices. OCADSV's mission is to: "Promote equity and social change in order to end violence for all communities. We seek to transform society by engaging diverse voices, supporting the self-determination of survivors, and providing leadership for advocacy efforts." For more information about OCADSV and this project, contact Lea Sevey at lea@ocadsv.org.

About OHA

Oregon Health Authority (OHA) has five full-time Suicide Prevention Coordinators spread across two divisions and three units and maintains a statewide suicide data dashboard. Despite being spread out among divisions and units, the Suicide Prevention Team works collaboratively and cohesively with the "no wrong door" principle. The OHA Suicide Prevention Team works closely with the Oregon Alliance to Prevent Suicide. For further information and collaboration, please contact Debra Darmata at debra.darmata@dhsoha.state.or.us.

About RRI

The Regional Research Institute for Human Services (RRI) is the research arm of the PSU School of Social Work at Portland State University. It has conducted research dedicated to improving the design, management, practice, and evaluation of human services and service delivery systems since 1972. It has served as the subcontracted evaluator for multiple SAMHSA grants awarded to OHA, including 3 Garrett Lee Smith youth suicide prevention grants, OHA's Zero Suicide Initiative and the COVID-19 Emergency Response to Suicide Prevention grant that funded this booklet. For more information about RRI and its work with suicide prevention, contact Karen Cellarius at cellark@pdx.edu.

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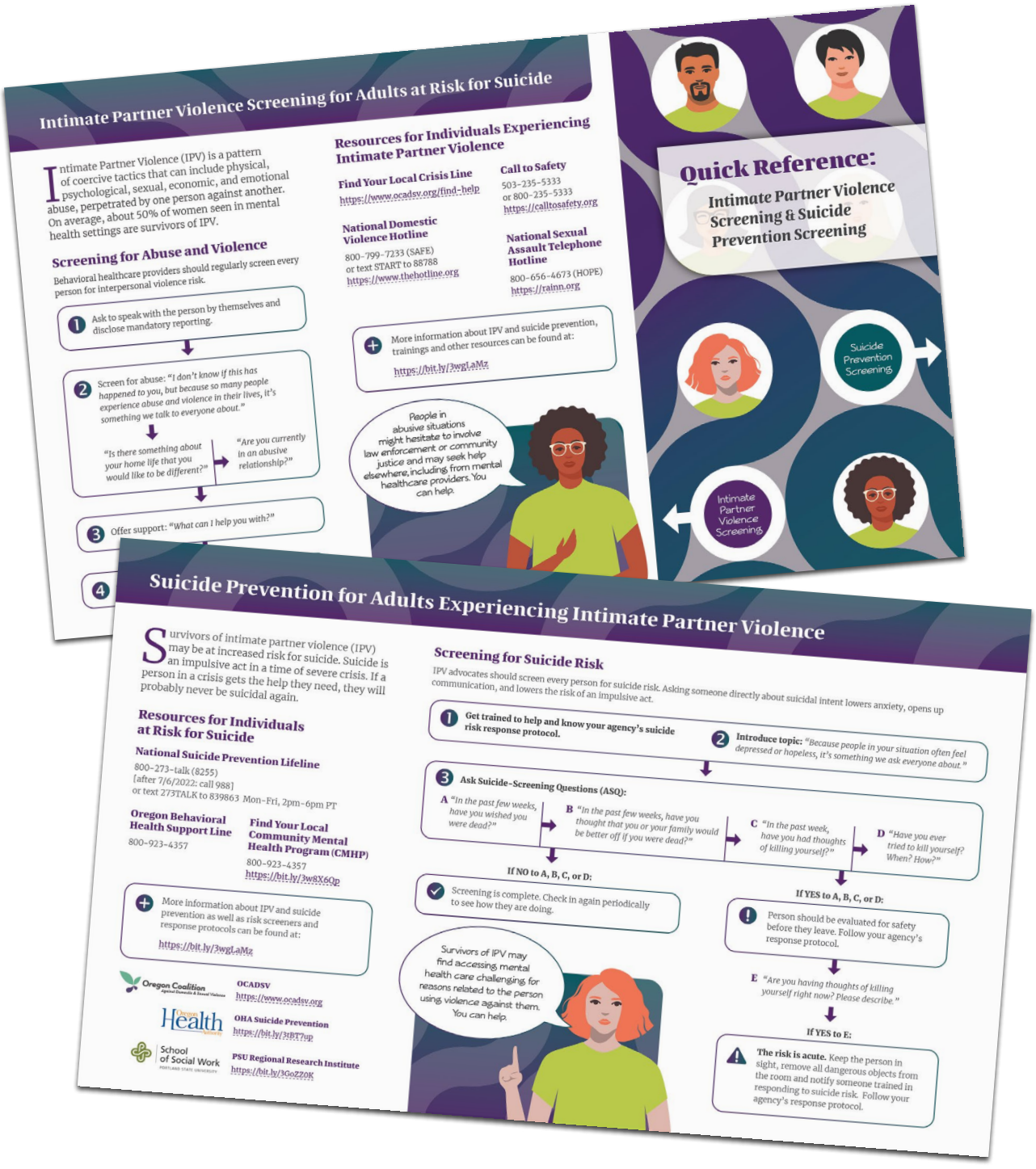


Quick Reference: Intimate Partner Violence Screening & Suicide Prevention Screening is available at https://bit.ly/3wgLaMz, along with an electronic version of this resource guide.

PART 1

The Intersection of Domestic Violence and Suicide

Background

Suicide was the 10th leading cause of death in 2019 for all ages in the US and the fourth leading cause of death for ages 35–54.[1] Deaths by suicide for females increased by 3.6% per year from 2009 to 2015, and in 2019 10,255 females died by suicide in the US.[2]

Large-scale disasters like COVID-19 can contribute to both DV risk and MH crises and result in an increase in calls to crisis centers. Lines for Life, Oregon's Suicide Prevention Hotline, has reported an increase of up to 30% in call volume since the COVID-19 emergency declaration in March of 2020. Local DV advocates report spending more time with victims seen in Emergency Departments, observing that the amount and intensity of physical violence has increased as well.

IPV survivors' experiences may increase their risk factors for suicide. Stress is a common experience for survivors of IPV, and chronic stress is a risk factor for suicide. IPV survivors also describe feelings of helplessness, depression, and "feeling trapped," which are all risk factors for suicide. Access to and involvement with mental health supports are protective factors for suicide risk. However, survivors of IPV may find accessing mental health care challenging for reasons related to the person using violence against them, their access to basic needs, their children, and the court system. In addition, the person using violence to control their partner can use social isolation as a control tactic; and social isolation is yet another suicide risk factor.

Lessons Learned from the COVID-ERSP Initiative

The lessons learned from this grant have been compiled into this booklet to help individuals working in mental healthcare and domestic violence to (1) understand the factors that contribute to domestic violence and/or suicide risk, (2) know how to ask someone if they are thinking of killing themselves and/or if they are experiencing violence in their home, and (3) what to do if the answer is yes.

In Fall 2021, PSU's RRI conducted a survey with the staff at the six sites with grant-funded domestic violence/mental health agency partnerships around Oregon. The 25 survey respondents shared the lessons their agencies learned from the project.

Lessons learned:

1. Cross-training staff in IPV and mental health is useful and desired by staff.
2. Jointly-created written referral protocols are useful pathways to coordinated care.
3. Coordinating services across agencies facilitates faster, more efficient care.
4. Proactive collaboration with area agencies can be challenging but is rewarding and helpful for service provision.

Staff cross-trained in IPV and mental health through the COVID-ERSP grant found the trainings to be very useful and expressed interest in additional training. Survey respondents told us that increased training, both in the provider's own field and cross-training, was the most helpful aspect of this funded project.

Action: Consider incentivizing your staff to watch training videos with a drawing for a small gift.

Domestic Violence Advocates who participated in this grant project highly recommend joining the local suicide prevention coalition to create partnerships with area service providers and elevate the work of DV agencies. DV Advocates told us that collaboration can be challenging, but rewarding and helpful for service provision. They found consistent communication with partner agencies, survivor follow-through in getting mental health support, and creating a coordinated, county-wide suicide prevention response to be a challenge. Advocates recommend setting up monthly informal "coffee check-ins" with area service providers, round tables, or "lunch and learn" opportunities to maintain connections.

The coordinated efforts for training were extremely valuable even for trainings that I already had. For example, the DV Webinars covered information I already held, but it was helpful to learn what our MH partners were learning.

—Domestic Violence Advocate

SAMHSA and the National Center on Domestic Violence, Trauma and Mental Health compiled a list of background information and resources for building effective partnerships that are listed below here and elsewhere in this document:

- Resources for Mental Health and Substance Use Treatment and Recovery Support Providers https://bit.ly/3FriGAv
- Resources on Substance Use Coercion http://www.nationalcenterdvtraumamh.org/2020/10/new-series-suc

This remainder of this booklet is divided into two sections, each with more detailed information, resources, training opportunities and interventions:

1. Suicide Prevention and Mental Health Tips for Domestic Violence Advocates
2. Domestic Violence Advocacy And Tips for Mental Health Professionals

Action: Consider creating written reciprocal referral protocols with partner agencies in your community.

PART 2

Suicide Prevention and Mental Health Tips for Domestic Violence Advocates

Introduction to Oregon's Mental Health Crisis Response System

Crisis Lines, Crisis Response, Community Mental Health Programs, and Caring Contacts[5]

The Oregon Health Authority (OHA) Health Systems Division describes its vision of a healthy Oregon where mental health disorders (and others) are prevented through education, early intervention, and access to appropriate health care.[6] They see this being accomplished through partnerships with individuals and agencies, providers, advocates and communities.

Community Mental Health Programs (CMHPs)

CMHPs are publicly-funded agencies that provide services for persons in the community who are experiencing mental health disorders, substance use disorders, or problem gambling disorders. Outpatient clinics may provide one or all service types. Behavioral Health Outpatient Programs include mental health, substance use (including Driving Under the Influence of Intoxicants and Synthetic Opiate Treatment), and problem gambling treatment and recovery services. Alcohol and Drug Screening Specialists (ADSS) are also certified and provide screening and referral services for individuals convicted of a DUII.

Services available through Community Mental Health Programs (CMHPs):

- Mental Health and Addiction Assessment and Treatment Planning
- Individual and Group Therapy
- Family Therapy
- Skills Training
- Case Management
- Care Coordination
- Crisis Services

- Psychiatric Medication Management
- Education and Consultation

Most Oregon communities are served by a specific CMHP. Find your CMHP by county https://www.oregon.gov/oha/hsd/amh/pages/cmh-programs.aspx?wp6627

Crisis Intervention Teams (CITs)/ Mobile Crisis Teams

Crisis Intervention Teams respond to behavioral health crises in the community. CITs are primarily jail diversion programs that aim to provide people in mental health crisis the care they need instead of incarceration. Many CMPHs have established CIT programs in collaboration with local law enforcement agencies to de-escalate crisis situations involving individuals with serious mental illness. CIT programs help to reduce officer and consumer injuries, reduce the arrests of people with mental illness, and increase referrals to treatment for people with mental illness.

Crisis Lines

Lines for Life is Oregon's statewide, 24/7 crisis call center for people in crisis or who need confidential help for drug addition, alchol abuse, thoughts of suicide, and other mental health issues. It is also the local responder to the National Suicide Prevention Lifeline (NSPL). Unless otherwise stated, the link to connect online with all these lines is http://www.linesforlife.org/content/get-help-now. Lines for Life operates following crisis lines:

- Mental Health Crisis/Suicide
  1-800-273-8255
- Military Helpline
  1-888-457-4838
- Youthline
  1-877-968-8491
- Senior Loneliness Line
  1-888-457-4838
- Alcohol and Drug Help Line
  1-800-923-4357
- Behavioral Health Helpline (OHA-funded 24/7 access to mental health support: Offers 3 free telehealth sessions to any Oregonian on a waitlist for a behavioral healthcare provider and a warm handoff to that provider once one becomes available.)
  1-800-923-HELP (4357): Option 3
  https://www.linesforlife.org/behavioral-health-support-line

A different provider, Oregon Problem Gambling Resource, offers free confidential help
1-877-MY-LIMIT (1-877-695-4648)
https://www.opgr.org

Caring Contacts

Caring contacts are brief communications between the patient and a provider to successfully transition the patient to outpatient services. The provider can be a behavioral health clinician, peer support specialist, peer wellness specialist, family support specialist, or youth support specialist. A provider may also be a crisis line counselor supervised by or working under the direction of a clinician. Peer support, peer wellness, family support, and youth support specialists are persons certified by the Oregon Health Authority, Health Systems Division who provide supportive services to persons receiving mental health or addiction treatment.

- Caring contacts can be facilitated through a contract with a qualified community-based behavioral health provider or through a suicide prevention hotline
- A caring contact may be conducted in person, telemedicine, or by phone
- A caring contact must be attempted within 48 hours of release from the emergency department if a patient has attempted suicide or experienced suicidal ideation

- A caring contact process is REQUIRED for patients who attempted suicide or experienced suicidal ideation and must occur within 48 hours of release.

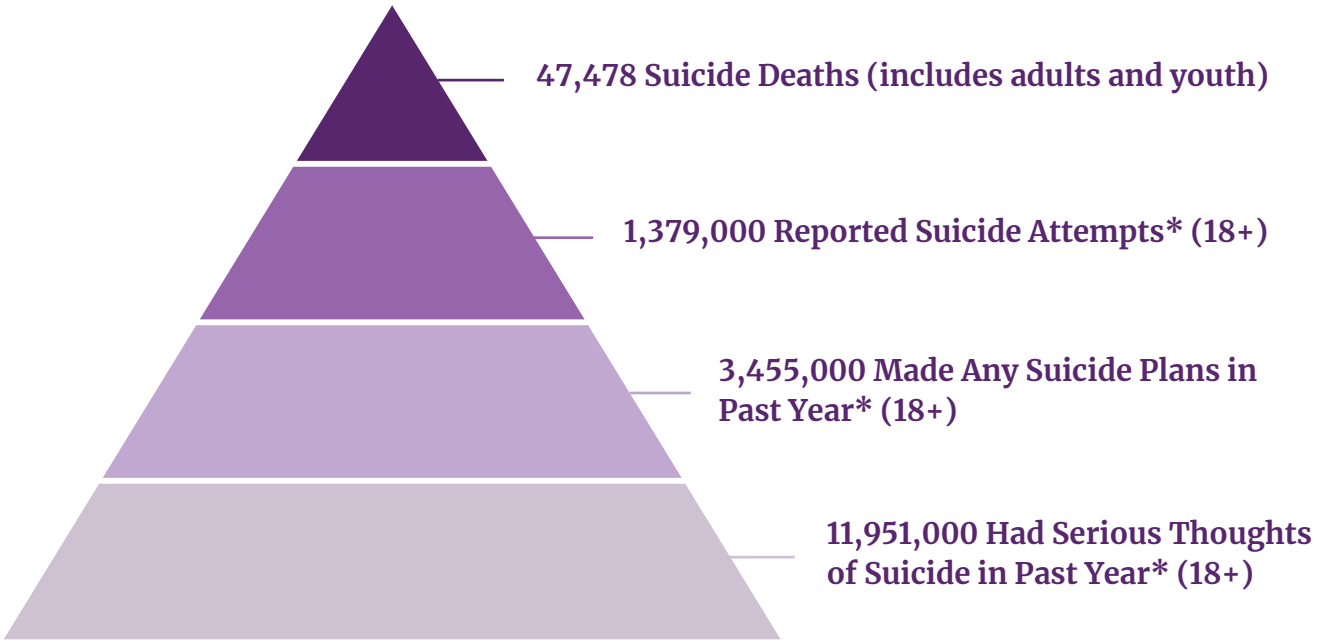
OHA's Health Systems Division works towards this goal through county response programs, called Community Mental Health programs (CMHPs). There is a CMHP in every county in Oregon.

Suicide is preventable!

Introduction to Suicide Prevention[7,8]

In the United States, there are 25 suicide attempts for every 1 suicide death. Females are 3 times more likely than males to attempt suicide, while males are 3.4 times more likely to die by suicide than females. Why? Males tend to use more lethal means.[9] Suicides account for 82% of firearm deaths in Oregon. When firearms are the method, nine out of every ten suicide attempts will be lethal. In 2018, there were 844 reported suicide deaths in Oregon, causing it to be 12th in the nation for suicide deaths. But the problem is much bigger. We don't see all of the attempts. The pyramid in Figure 1 visualizes the extent of the problem.

Figure 1. Suicidal Behavior, United States 2019[10]



**Self-Report*

Suicide is Preventable

Suicide is an impulsive act in a time of severe crisis. If people in a crisis get the help they need, they will probably never be suicidal again. Asking someone directly about suicidal intent lowers anxiety, opens up communication, and lowers the risk of an impulsive act.

The Argument for Cross-Training IPV Advocates in Suicide Risk and Prevention

Of the 844 reported suicides in Oregon in 2018, nearly 1 in 4 suicides listed "Intimate Partner Problems" as a "stressor" associated with the suicide, and 8% of decedents were in an immediate crisis with their intimate partner. Among women enrolled in a large health maintenance organization, 44.0% reported having experienced physical, sexual, and/or psychological IPV in their lifetime.

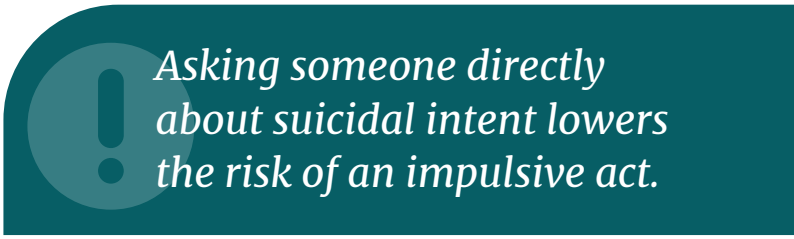
Suicide risk factors manifest themselves during survivor experiences. Cross-training mental health workers and DV advocates can help create a stronger safety net, where mental health workers know the risk factors or symptoms of DV, and you all know the risk factors and symptoms of suicide. There are multiple suicide risk factors and people can experience more than one at the same time. Survivors of domestic violence are obviously under a variety of stressors. These stressors are associated with suicide risk factors. These suicide risk factors include what mental health clinicians would observe under the diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, or PTSD.

Table 1 on the following page highlights the importance of cross-training. You can see how the experiences of survivors feed directly into suicide risk. There are additional risk factors not listed here, but this is a start to watch for in your advocacy work. You'll see the list of experiences are very familiar and the commonalities will jump out at you. They are also the risk factors for suicide. This is why it is so important for crisis advocates to be adept at having conversations with survivors about suicide.

Where Do You Fit in?

Everyone can do their part to prevent suicide. The Suicide Prevention Resource Center identifies nine strategies[11] that form a comprehensive approach to suicide prevention and mental health promotion:

1. Identify and assist persons at risk
2. Increase help-seeking
3. Ensure access to effective mental health and suicide care and treatment
4. Support safe care transitions and create organizational linkages
5. Respond empathetically to individuals in crisis
6. Provide for immediate and long-term postvention
7. Reduce access to means of suicide
8. Enhance life skills and resilience
9. Promote social connectedness and support



Suggestions from IPV Advocates Participating in the COVID-19 ERSP Grant

In a survey of the COVID-19 grant partners in late summer 2021, DV respondents identified three recommendations for DV advocacy organizations:

1. Screen every person served for suicide risk. It's a part of safety planning.
2. Work to increase communication with local CMHPs. This communication can lead to better follow-through for IPV survivors. Some ERSP sites did this by identifying a specific contact person or the suicide prevention specialist at the CMHP and developing a connection by talking

on the phone, in person, or going out to coffee. Developing written protocols on how to refer clients to each agency can also help.

3. If there is a county suicide prevention coalition, join it! Coordinated, county-wide suicide prevention response is helpful. Local IPV programs should have a voice at the table.

Table 1. Overlap of IPV Survivor Experiences and Suicide Risk Factors

Suicide Risk Factors	IPV Survivor Experiences
· Chronic stress/ disease/disability · Depression, mood disorders, and other mental health disorders	· Cognitive effects of trauma and stress on decision-making: Fear, shame, lack of confidence & trust. Toxic stress on the body & brain · Helplessness is an emotional indicator of surviving abuse · Depression: Roughly 63% of survivors of DV also experience depression, compared to 10.4% of the general population · Psychiatric Disorders: 20% of DV survivors report experiencing a new onset of psychiatric disorder (depression, anxiety, PTSD, substance use disorder) · Barriers to seeking/accessing supports: Mental health challenges/ diagnoses are often a barrier to housing and shelter
· Social Isolation	· Isolation from family, friends, and from professional help · Stigma exists for people experiencing mental health challenges · Credibility is often challenged or undermined
· Lack of access/ involvement with mental health care	· Diagnoses and medication are used to gain power and control · Survivors are reluctant to engage with mental health services due to fear of children being taken into state care · Difficulty in finding affordable and consistent support
· Misuse and abuse of alcohol/drugs	· Self-medicating as a coping mechanism is common
· Prior suicide attempts · Access to lethal means	· Access to objects capable of being lethal weapons increases the lethality probability

Suicide Screening Tools and Content

Anyone can screen someone for depression and suicide risk. There are even self-screeners. However, people are hesitant to screen for suicide risk because they don't know what to do if someone screens positive. Suicide prevention trainings and organizational response plans are great places to start. Commonly used evidence-based suicide risk *screening tools* include the ASQ, PHQ-9 and the C-SSRS. In contrast, suicide risk and mental health *assessments* are more detailed and best done by a mental health professional. Assessments provide a specific mental health diagnosis and are the basis for developing a treatment plan. For this reason, this booklet only addresses screening tools.

Words Matter (Think about it!)

Do Not Use These Terms:	Instead, Use:
· Failed attempt · Committed suicide · Successful suicide	· Aborted Suicide · Interrupted Suicide · Died by Suicide · Killed themselves · Suicided
No longer recommended: · Suicide survivor (It's confusing!)	· Attempt survivor · Loss survivor · Close friend of..., family member of...

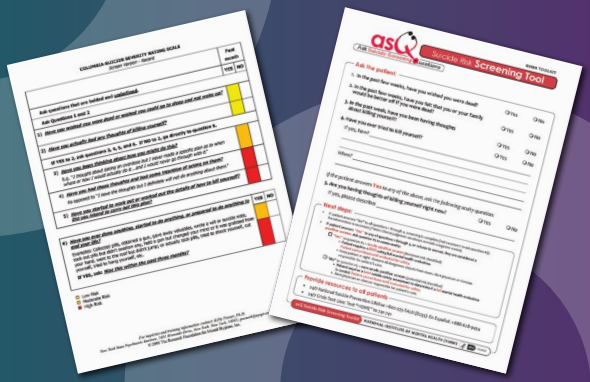
Columbia Suicide Severity Rating Scale (C-SSRS) was developed by Columbia University. Agencies like the NIH, CDC, SAMHSA, DoD, and WHO all endorse this tool. You do not need training to use this tool, but training and practice are helpful. The Columbia or C-SSRS is a series of simple questions anyone can ask. There are three main parts:

1. Ideation: Whether and when they have thought about suicide
2. Preparedness: What actions they have taken, and when, to prepare for suicide
3. Attempts: Whether and when they attempted suicide or began a suicide attempt that was interrupted (by someone else or themselves)

Suicide Prevention Tips

- Ask the question! (Don't be afraid to ask someone if they are thinking of killing themselves.)
- Ask if they have a plan.
- Offer connections to community mental health programs, crisis phone line numbers, and resources.

The C-SSRS & The ASQ



(See Part 4, Tools)

The Ask Suicide-Screening Questions (ASQ) tool is a set of four brief suicide screening questions that takes 20 seconds to administer. Detailed information on the tool and how to use it is available at the ASQ Toolkit website.[12]

The nine-item Patient Health Questionnaire (PHQ-9) is a depression screener that is often used to screen for suicidal ideation. Item 9 evaluates passive thoughts of death over the past two weeks.

Some studies have found it to be insufficient as a stand-alone suicide risk screener,[13,14] and it is usually used in combination with the CSSRS.

How to Introduce the Screening Tool to Clients – Variation of DV Screening Tool Script

The process for introducing a suicide risk screener is similar to the process for screening for IPV.

> *"I don't know if this has happened to you, but because so many people experience these thoughts in their lives, it's something we always ask about. Could you tell me…"*

Brief suicide prevention trainings provide an opportunity to practice bringing up the topic of suicide. Question, Persuade, Refer (QPR) is a good one, is free, and only takes one-two hours. QPR is available online, and there may also be in-person training opportunities in your community.

Table 2. Assessments Vs. Screenings

	Suicide Risk Screenings	Mental Health Assessments
Who Can Administer	*Anyone* can screen	Mental Health Professionals
What	Screens for suicide risk: · CSSR-S · ASQ · PHQ-2 or PHQ-9	· Provides a diagnosis · More detailed · Basis for treatment plan
Who Should Be Screened or Assessed?	All IPV survivors should be screened following a major event, or more frequently for individuals suffering from chronic episodes of violence	Anyone who screens positive for depression, suicide risk or a related MH condition

Incorporating Suicide Risk Screening and Referral into Crisis Line Response

- Establish immediate physical safety
- Ask "How can I be of support for you right now?"
- Conduct suicide risk screening
- Provide resources, including suicide safety plan if applicable and referral and/or warm hand-off to mental health agency

Next Steps After a Positive Suicide/Depression Screen

Many people don't want to ask the questions because they don't know what to do if someone discloses that they are feeling suicidal. We'd like to provide some suggestions about what to do next and provide some examples of referral procedures from DV agencies in Oregon.

Referral Procedures from IPV Advocates to Mental Healthcare Providers

Best practices for writing referral protocols (COVID-19 ERSP Grant DV Advocate's suggestions)

- Create a narrative or FAQ document to help facilitate referrals from CMHPs to your agency.
- Work with your CMHP to set up telehealth services. They may be able to provide devices like tablets or phones to your agency to increase telehealth access.
- Connect with your local partners by designating an advocate to connect with each one:
  - Local CMHP
  - Crisis teams *(Caution! Crisis teams are often accompanied by law enforcement, which may be triggering for individuals who have had adverse experiences with police in the past.)*
  - County Suicide Prevention Coordinator
  - Local/regional Suicide Prevention Coalition
- Discuss the difference between confidentiality and privilege with your CMHP when creating referral pathways.

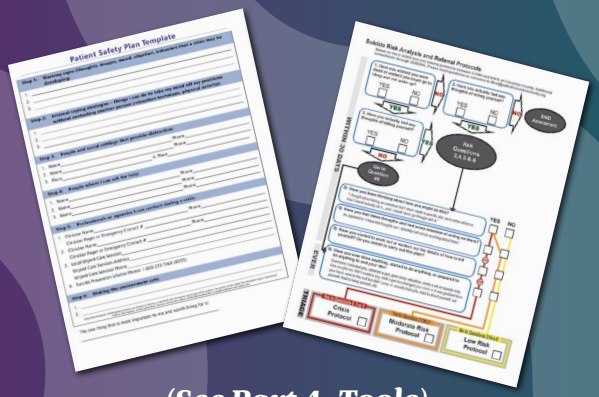
Safety Planning for Suicide Risk: The Stanley Brown Safety Plan

One tool used by mental health providers is the Stanley Brown Safety Plan. Many agencies have it built into their electronic health record system. Similar to safety planning you already do with survivors, this Stanley Brown Safety Plan is a prioritized list of coping strategies and sources for support for persons at risk for suicide. You could use this tool as well. Think of safety planning like this:

- Safety Plan for Interpersonal Violence: *keeping the body safe*
- Safety Plan for Mental Health/Suicide Risk: *keeping the mind safe*

The plan should be brief, in the survivor's own words, and easy to read and follow. It is a template for a prioritized list of coping strategies and sources for support for persons at risk for suicide.

The Stanley-Brown Safety Planning Tool & The Suicide Decision Tree



(See Part 4, Tools)

Figure 2. Co-Located Advocacy Poster

Resources and Ways to Connect with Broader Suicide Prevention Efforts in Oregon

This book is not meant to be a comprehensive guide to working with adults at risk for suicide. There are a lot of other resources out there and online sources for the most up-to-date information. Here are some of them:

- Recommendations for Suicide Prevention Hotlines on Responding to Intimate Partner Violence (59 pages!) https://bit.ly/3K5Ci0m
- Oregon Alliance to Prevent Suicide https://bit.ly/3fzCSFD
- List of regional suicide prevention coalitions https://bit.ly/3I85ceO
- The Suicide Prevention Resource Center https://www.sprc.org
- OHA Suicide Prevention Listserv https://bit.ly/3rppGZw
- SAMHSA's two-part webinar on suicide and intimate partner violence. Part 1: https://bit.ly/3I7FaIm; Part 2: https://bit.ly/3nzuhrc
- My3 Support Network app, available in Apple and Android app stores, allows individuals to define their support network and their plan to stay safe
- Annual Oregon Suicide Prevention Conference, October. https://bit.ly/340j67f

Get Trained to Help!

Suicide prevention trainings for IPV advocates in the ERSP grant resulted in increased comfort levels with approaching the subject with clients, but even more training was desired. Increased comfort means Advocates are more likely to talk about suicide when screening crisis calls. After your first training, consider arranging a class for your office. Take it to the next level by scheduling annual suicide prevention trainings and making it part of onboarding new staff.

There are multiple evidence-based suicide prevention trainings available in Oregon. Many of them are free. For more information, go to https://www.linesforlife.org/training

Trainings in Oregon

QPR: Question Persuade Refer is a 1-2 hour training that teaches individuals to recognize someone at risk, intervene with confidence and competence and refer them to the appropriate source to receive the help they need.

ASIST: Applied Suicide Intervention Skills Training is offered over two full days and intended for Providers, Educators, Call Counselors, Community Members. This two-day intensive, interactive workshop provides participants with the skills to assist in suicide intervention. The class is composed of lectures, small group discussions, and interactive exercises. ASIST also includes demonstrations and role-playing of common suicide intervention situations, allowing participants to practice their newly learned suicide intervention skills in a supportive environment.

safeTALK: Suicide Alertness for Everyone – Tell / Ask / Listen / Keep safe is a 3.5-hour training intended for community members. Participants learn how to identify people that are having thoughts of suicide, confirm that thoughts of suicide are present, and connect the person to resources.

Mental Health First Aid (MHFA) is an all-day training intended for providers, educators, and community members. Participants learn how to identify, understand, and respond to indicators of mental illness and substance abuse.

Youth Mental Health First Aid (YMHFA) is intended for Youth-serving Adults, Parents, Educators, Community Members. It focuses on helping youth (age 12-18) navigate through mental health crises, bullying, and substance use.

OHA's Big Six Programming/ Trainings are available in Oregon through the following contacts:

- *ASIST or safe TALK:*
  Tim Glascock, AOCMHP
  503-367-3754
  tglascock@aocmhp.org
  http://www.aocmhp.org
- *CONNECT:*
  Kris Bifolio, AOCMHP
  kbifulco@aocmhp.org
- *QPR:*
  Colleen Cadell, Lines for Life
  503-332-5807
  qpr@linesforlife.org
- *Sources of Strength (SOS):*
  Liz Thorne, Matchstick Consulting
  503-593-2840
  liz@matchstickpdx.com
  https://matchstickpdx.com
- *MHFA:*
  Maria Pos, AOCMHP
  503-399-7201
  mpos@aocmhp.org

PART 3

DV Advocacy Tips for Mental Healthcare Providers

Introduction to Intimate Partner Violence, Domestic Violence, and Sexual Assault

The purpose of the Oregon Coalition Against Domestic and Sexual Violence (OCADSV) is to provide support to Oregon's domestic and sexual violence emergency programs. OCADSV defines IPV as a pattern of coercive tactics that can include physical, psychological, sexual, economic, and emotional abuse, perpetrated by one person against another, with the goal of establishing and maintaining power and control.[15] The formal definitions of unlawful acts that fall under the categories of Intimate Partner Violence, Domestic Violence, and Sexual Assault can be found in Oregon Revised Statute 107.705.[16] IPV affects people in all life stages, of all races, and regardless of gender identity. Roughly one in five homicides are women killed by their intimate partner and is the seventh leading cause of premature death for women in the U.S.[17] Prior domestic violence is the major risk factor for intimate partner homicide, regardless of the gender of the victim.[18]

Helpful Definitions

Sexual Violence: Sexual contact or behavior that occurs without the explicit consent of the victim.

Domestic Violence: Violence among people in a domestic situation including current and former spouses, partners, and other family members such as siblings, parents, aunts, and uncles.

Intimate Partner Violence: Violence perpetrated by a partner in a romantic or dating relationship.

Interpersonal Violence: Intentional use of force, violence, or power against other persons or by an individual or small group of individuals. This is the broadest definition.

Survivor: Someone who is surviving a current or past interpersonally violent situation.

Common terms:

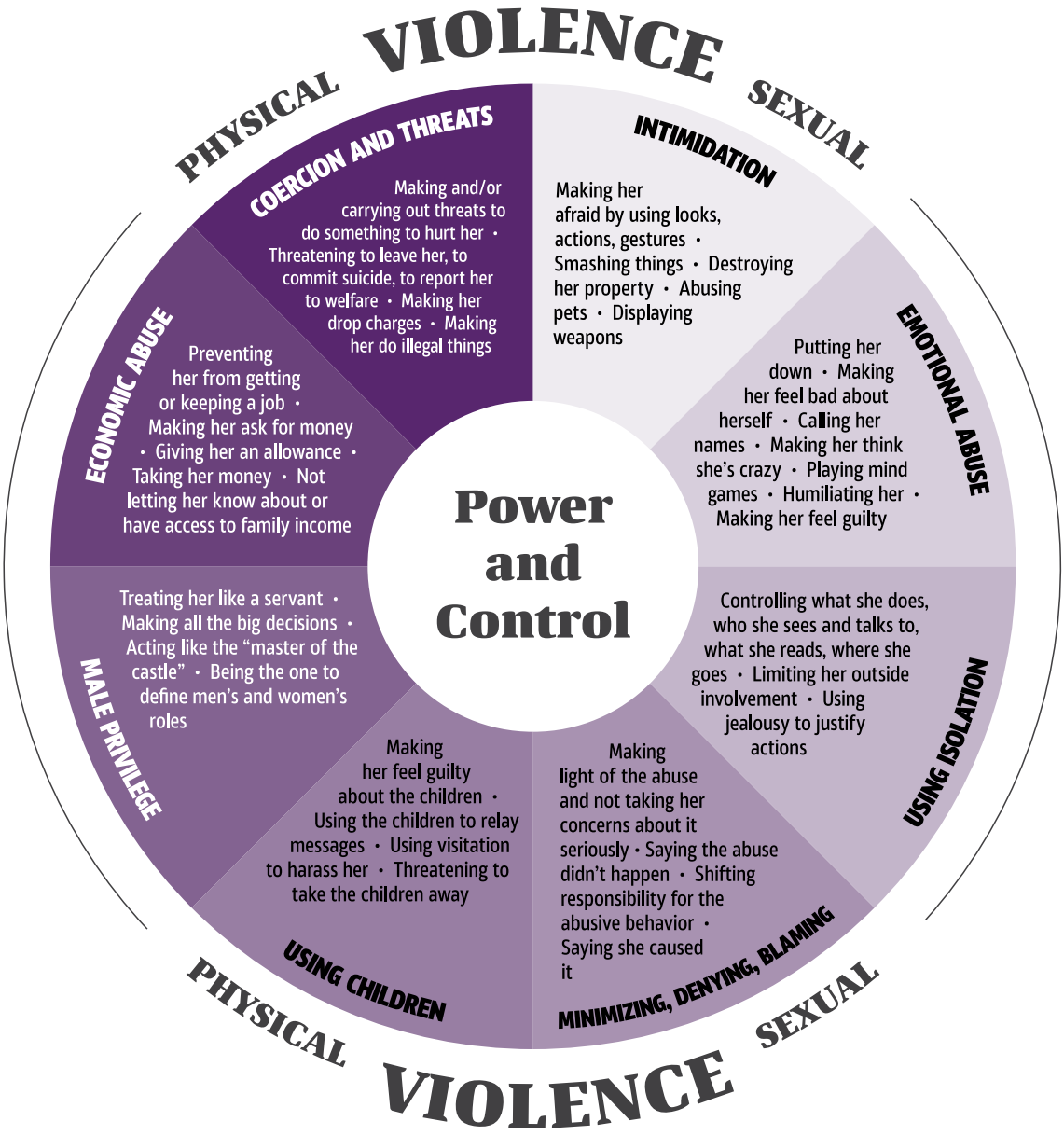
- Victim, Survivor
- Perpetrator, Abuser, Primary Aggressor

Oregon's Interpersonal Violence Support System

Communities can work towards creating protective environments with decreased IPV by teaching safe and healthy relationship skills in early life, engaging and influencing adults and peers, disrupting developmental pathways towards partner violence, and strengthening economic supports for families.[19]

Communities can also work collaboratively to support survivors to increase safety and decrease harm. IPV Advocacy organizations across Oregon work with survivors of Interpersonal Violence, Domestic Violence, and Sexual Abuse/Assault of all genders. Strong partnerships between DV advocacy agencies and mental health agencies can be a key aspect of a protective environment.

Figure 3. Power and Control Wheel



What Do DV/SA or IPV *Advocacy Organizations* Do?

OCADSV is the statewide coalition serving community-based emergency shelter programs for survivors of Intimate Partner Violence (IPV), Domestic Violence and Sexual Assault (DV/SA). It includes over 50 community-based programs throughout Oregon, including ones that are tribal and/or culturally specific. OCADSV hosts an annual conference, organizes for the interests of survivors through policy and helping to shape state legislation, and hosts special interest workgroups. Every county has a Domestic Violence/Sexual Assault (IPV) crisis response agency, and most have an emergency shelter program for survivors who need emergency housing.

Find your local IPV Agency at https://www.ocadsv.org/about-us/coalition-members

Advocates don't give advice or direct survivors – they provide support for the survivor to choose for themselves among a variety of resource options.

Every IPV program has a connection to their Community Mental Health Program, and in some counties, DV advocates are also co-located in DHS child welfare and self-sufficiency offices.

Find out if there is a co-located advocate in your county at https://www.oregon.gov/dhs/ABUSE/DOMESTIC/Pages/index.aspx

What Do IPV *Advocates* Do?

IPV advocates are trained to support the survivor through a trauma-informed, survivor-centered approach. Advocates provide direct services and also connect survivors with other services in their community. Services offered at most IPV Agencies include:

- 24 Crisis telephone line response and in-person crisis response
- Individual safety planning
- Court proceedings assistance, including assistance with protective orders and system navigation and accompaniment
- Connections to community resources, including assistance accessing supports from the Oregon Department of Human Services (DHS), Employment Department, Community Action Committees, and Behavioral Health agencies
- Housing, including emergency safe housing, transitional housing programs, and cash assistance for rent, utilities, and other expenses
- Basic needs support

Why Don't Survivors Just Leave?

Although it is usually best for survivors to leave an abusive situation, people using violence to maintain power and control often take many actions to prevent someone from leaving. On average, it takes about seven attempts to leave before a person leaves an abusive relationship for good. About 75% of domestic violence homicides were killed as they attempted to leave the situation or after the relationship had ended.[20] Over 56% of female survivors of IPV said they were concerned for their safety.[21]

Survivors also may have nowhere to go. In Oregon in 2018, there were about 2,200 shelter stays and over 8,000 unmet requests for shelter.[22] People sometimes stay in abusive relationships because of: (1) concern for their children, (2) community or societal pressures, (3) cultural expectations, (4) fear of deportation, (5) involvement with the justice system, and/or (6) fear of damaging their reputation or other personal relationships. Asking this question suggests the survivor is to blame for not leaving the situation. In reality, there are many factors in the decision to stay or leave. Instead, offer a warm handoff to DV and mental health agencies along with other local resources.

The Importance of Cross-Training Mental Health Providers in IPV Identification and Response

According to the CDC, about 1 in 4 women and 1 in 10 men experience an IPV-related impact in their lifetime.[23] Intimate partner violence does not always result in injury. Of the estimated 4.8 million sexual assaults perpetrated against women by their initiate partner, only about 500,000 will result in some type of medical treatment to the survivor, and most intimate partner victimizations are not reported to the police (ibid).

People in abusive situations might hesitate to involve law enforcement or community justice and may seek help elsewhere, including from mental health service providers. In a study from 11 US cities in 2001, 66% of women who were murdered by their intimate partner had visited a health care agency in the year before their death and 41% had visited a mental health care agency.[24] On average, about 50% of women seen in mental health settings are survivors of intimate partner violence.[25] The most common diagnoses for these women include PTSD, depression, and anxiety. About 20% of IPV survivors reported experiencing a new onset of psychiatric disorders, including major depressive disorder, generalized anxiety, and post-traumatic stress, along with a range of substance use disorders. In general, 37-63% of IPV survivors experience depression compared to about 10% of the general population. About 60% of women who are diagnosed with a serious mental illness are also survivors of sexual and/or physical abuse. Mental health providers who are trained to identify a survivor of IPV could be a lifesaver by referring them to IPV agencies and connecting them with appropriate resources.

Factors that May Affect an IPV Survivor's Ability to Attend Scheduled Mental Health Visits

Survivors of domestic violence may find it difficult to go to a scheduled mental health appointment due to the effects of their abusive situation. The person using violence may not want them to be able to access behavioral healthcare appointments, or the survivor may be afraid that the other person will use their mental health system engagement against them in court. The person using violence may have micromanaged the survivor's everyday life, making scheduling difficult and isolating them from help in the past. Additionally, about 60% of female survivors of IPV report symptoms of PTSD,[26] and the effects of living with trauma or chronic trauma sometimes make future planning and scheduling difficult. Finally, living in an abusive situation and/or fleeing from one can result in a lack of access to multiple resources, making management of day-to-day appointments or other responsibilities difficult. Resources that are often lacking for IPV survivors include:

Action: Provide day-of reminders for appointments and flexibility in scheduling.

- transportation
- gas money
- child care
- private means of communication
- stable housing
- income
- basic necessities of everyday life

Confidentiality, Privilege, and Mandatory Reporting (It's important to know the difference!)

Mandatory reporting requirements may influence the information a survivor chooses to disclose. Survivors' safety may be at risk if they disclose something that requires reporting to law enforcement. IPV Advocates are not mandated reporters, but most mental health providers are. OCADSV recommends mandated reporters always disclose their legal requiremements before asking questions that may prompt an answer that requires reporting. By informing a survivor of IPV that you are a mandatory reporter at the beginning of each appointment you are helping to keep them safe.

What Is Certified Advocate-Survivor Privilege?

Oregon law[27] protects communication between a certified advocate and a survivor. IPV advocates are not mandated reporters. Survivors may disclose information to advocates because of this, and a court cannot force the survivor or the advocate to discuss their communications.

Table 3. Certified Advocate-Survivor Privelege and Confidentiality

Certified Advocate-Survivor Privilege	Confidentiality
• Legal protection for survivors and certified advocates • Survivors can decide to disclose their confidential communication with a third party or not. (ORS 40.264)	• DV Agencies are not covered by HIPAA • DV Advocates are not mandatory reporters
"A court cannot force a victim or their advocate to disclose the contents of confidential communications, and neither the advocate nor the survivor can be punished for refusing to disclose the information."	**Best practice:** MH Providers communicate mandatory reporting requirements at the beginning of every appointment.

Why Is this Important?

DV Advocates work with survivors to regain control over aspects of their life. When survivors lose control of their information it may be used against them in divorce, custody, child welfare, and criminal cases. It may also affect their employment, education, or housing, and affect the survivor's health by potentially re-traumatizing them. Privacy is especially important in some settings, like rural communities, tribal communities, survivors experiencing homelessness, LGBTQ+ survivors, and immigrants.

Mandatory reporting requirements for mental health providers and certified DV advocate privilege laws are designed to keep individuals safe. We recommend IPV and mental health agencies work together to create referral and warm handoff protocols that are in line with both requirements.

Advocates in this program told us when they worked with their partner mental health agency and created written protocols for both agencies that navigated confidentiality and privilege, (1) more survivors got help from both agencies and (2) they were able to access that help more quickly.

How to Screen for Interpersonal Violence

OCADSV recommends that primary and behavioral healthcare providers screen every person for interpersonal violence risk as a parallel practice to suicide risk screenings. First, ask to speak with the person by themselves. Then, screen for interpersonal violence.

Suggested IPV Screening Steps

1. Disclose mandatory reporting
2. Screen for abuse:

   "I don't know if this has happened to you, but because so many people experience abuse and violence in their lives, it's something we talk to everyone about."

   - *"Is there something about your home life that you would like to be different?"*
   - *"Are you currently in an abusive relationship?"*

3. Offer Support

   "What can I help you with?"

4. Provide contact information for local IPV Agency and offer a warm hand-off
   - Phone Number (text crisis line if available)
   - Websites
   - Email address for the agency
   - Social media handles

Best Practices for Warm Hand-Offs to IPV Advocacy Organizations

1. Create a written policy for warm hand-offs in partnership with your local DV Agency, both from your MH agency to the DV agency and visa versa.
2. Create a narrative or FAQ document to help facilitate referrals from DV agencies to your mental health agency.
3. Work with your area DV agency to set up tele-health services. Lack of access to mental health support for survivors of domestic violence is an ongoing challenge.
4. Connect regularly with your local partners at monthly coalition meetings, informally through shared meals, or by co-locating a provider at each others' agencies. Local partners could include:
   - Your local DV Agency
   - Crisis teams *(Caution! Crisis teams are often accompanied by law enforcement, which may be triggering for individuals who have had adverse experiences with police in the past.)*
   - Oregon Coalition Against Domestic and Sexual Violence (OCADSV)

IPV Screening Dos and Don'ts

- ✕ Don't blame the survivor
- ✕ Don't ask "Why don't you just leave?"
- ✓ Do offer a warm handoff to a domestic violence agency

Warm Hand-Offs

Ideally, a warm hand-off:

- Occurs anytime from initial contact to the time of discharge
- Is face-to-face (in-person or via telehealth)
- Involves the patient and a community provider, in this case, a IPV Advocate

Resources for Building Effective Partnerships with DV Programs[4]

- SAMHSA/ACF Information Memorandum Calling for Collaboration Between the Mental Health, Substance Use and DV Fields https://bit.ly/3zVcjnH
- HIPAA Privacy and Security Rules FAQs for DV Programs https://www.techsafety.org/hipaa-privacy-security-tech-faqs
- HIPAA vs. VAWA/FVPSA/VOCA Comparison Chart https://www.techsafety.org/privacy-comparison
- Response to Subpoenas for DV Programs https://www.techsafety.org/how-to-respond-to-a-subpoena
- Release of Information for DV programs https://www.techsafety.org/releasesfaq
- NNEDV Confidentiality Toolkit https://www.techsafety.org/confidentiality

Connecting with an IPV Crisis Line

A call with a crisis line may be the first time a survivor of domestic or sexual violence talks about their experiences. Crisis line workers are trained to provide support to survivors as well as friends, family members, and community partners. As a mental health provider, you can call a IPV crisis line yourself and hand the phone to the person you are working with.

- National Domestic Violence Hotline
  1-800-799-7233 (SAFE) or text START to 88788
  https://www.thehotline.org
- Call to Safety (formerly the Portland Women's Crisis Line)
  503-235-5333 or 1-800-235-5333
  https://calltosafety.org
- National Sexual Assault Telephone Hotline
  800-656-4673 (HOPE)
  https://rainn.org/about-national-sexual-assault-telephone-hotline
- Find your local crisis line
  https://www.ocadsv.org/find-help

A Word About the Intersection of Suicide Risk and Risk Assessments on IPV Crisis Lines

While being with someone is a protective factor for suicide risk, IPV advocates often ask "are you alone?" to determine safety. If a survivor cannot talk without their abuser present, they are at an increased risk for IPV. When screening for both suicide risk and interpersonal violence, the answers to the questions in Table 4 have different meanings.

DV Training Opportunities

- OCADSV Webinar Series: DV & Mental Health. These 5 in-depth webinars for mental health providers are available for free on OCADSV's website at https://bit.ly/3qpB748

Table 4. Determining Safety with Screening

	Suicide Risk Screening	IPV Crisis Line
Answer to "Is someone else with you right now?" = yes	Decreased Risk ↓	Increased Risk ↑
Answer to "Do you have an action plan?" = yes	Increased Risk ↑	Decreased Risk ↓

OCADSV Webinar Topics:

1. Safety & Ethical Considerations for MH Providers Responding to DV
2. Understanding DV: Beyond Physical Abuse
3. Screening for DV by Mental Health Professionals
4. Intervening in DV for MH Professionals
5. DV Safety Planning for MH Professionals

- Futures Without Violence maintains a comprehensive website that supports health-care providers with training opportunities, a semi-annual e-bulletin, and templates.

Ways to Connect to Broader Domestic and Sexual Violence Advocacy Efforts in Oregon

- Join your local IPV advocacy agency as a volunteer
- SATF (Sexual Assault Task Force) - resources http://oregonsatf.org
- OCADSV list of resources and fact sheets https://www.ocadsv.org/resources/fact-sheets
- Language-specific IPV services in Oregon https://www.ocadsv.org/find-help
- Oregon Legislature https://bit.ly/3qugIuS

National Resources for Working with Survivors of DV in Mental Health Settings[4]

- Recommendations for Suicide Prevention Hotlines on Responding to Intimate Partner Violence https://bit.ly/3tz1GWu
- Mental Health Treatment in the Context of Intimate Partner Violence https://bit.ly/3qtoFAD
- A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors https://bit.ly/320iF92
- Toolkit on Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence https://bit.ly/3Ia0KfD
- Online Repository of IPV-Specific Interventions https://bit.ly/33aJF6t
- Safety Planning (NDVH) https://www.thehotline.org/resources/staying-safe-during-covid-19/
- IPV Safety Planning App https://www.myplanapp.org

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NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Suicide Risk Screening Tool

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍Yes ❍No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍Yes ❍No
3. In the past week, have you been having thoughts about killing yourself? ❍Yes ❍No
4. Have you ever tried to kill yourself? ❍Yes ❍No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍Yes ❍No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
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Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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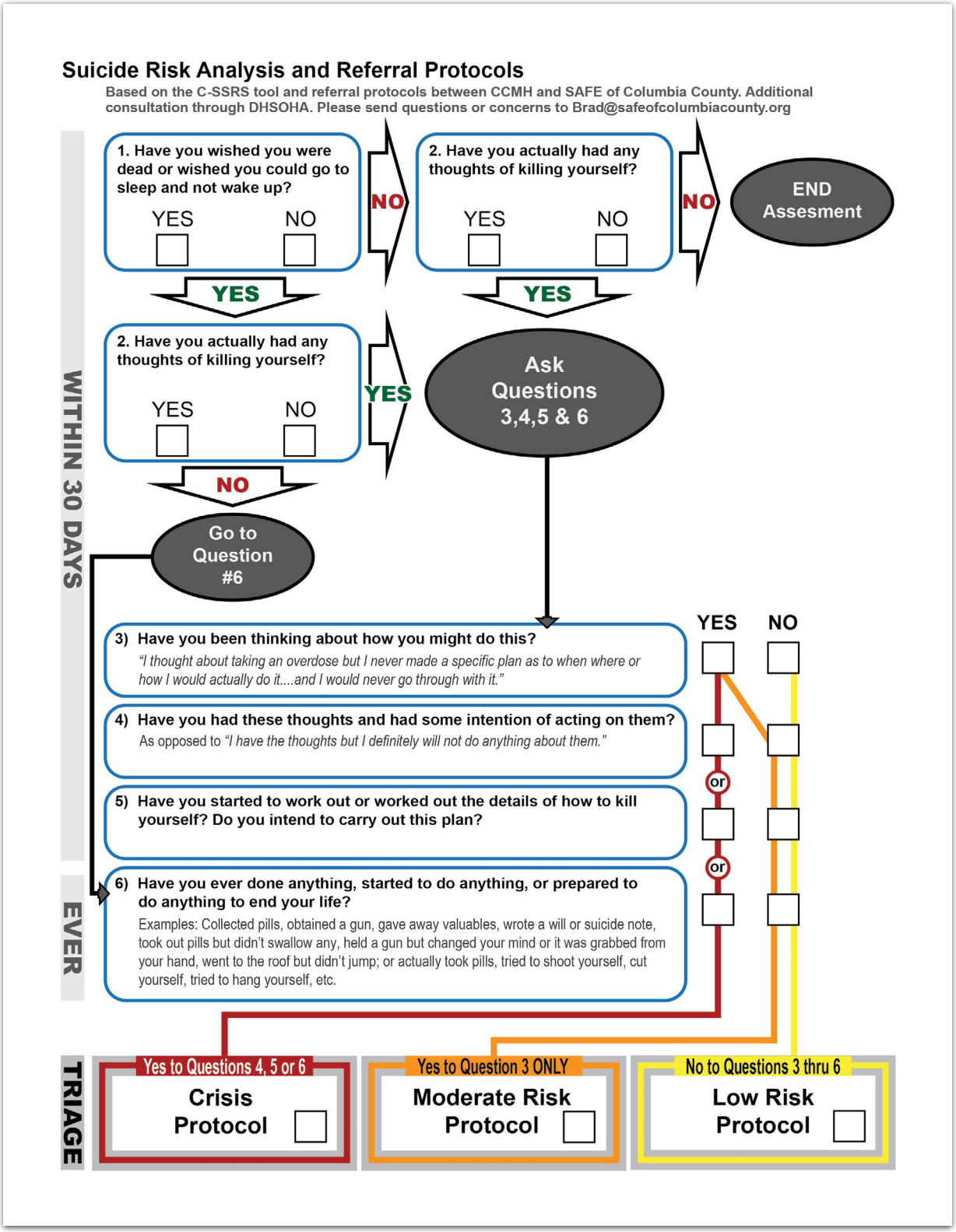
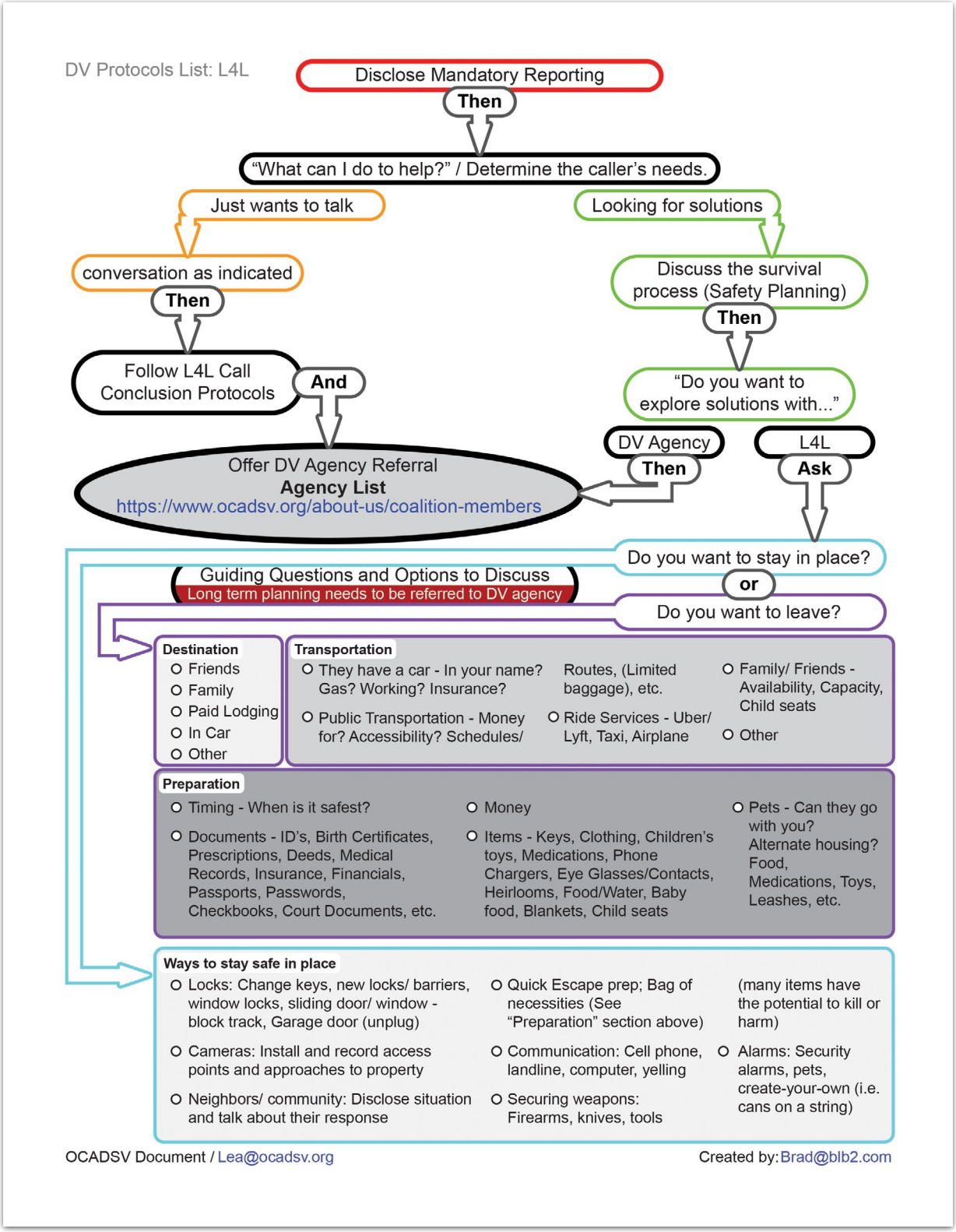
The one thing that is most important to me and worth living for is:

_____

PART 4, TOOLS: SAMPLE DECISION TREE FOR DV ADVOCATES SCREENING FOR SUICIDE RISK



PART 4, TOOLS: SAMPLE DECISION TREE FOR MH CRISIS LINE STAFF SCREENING FOR DOMESTIC VIOLENCE



Oregon Coalition Against Domestic and Sexual Violence (OCADSV)

https://www.ocadsv.org

Oregon Suicide Prevention

https://www.oregonsuicideprevention.org

Oregon Health Authority Suicide Prevention

https://bit.ly/3tBT7up

Portland State University Regional Research Institute

https://bit.ly/3GoZZ0K

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https://bit.ly/3wgLaMz