

# 3.1 The Importance of Safe Conversations: Identifying Risk and Resources

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## 3.1.1 Introduction

Assessing safety with respect to mental health and substance use involves having conversations with the women we work with about these aspects of their lives. The answers they give can be used to work collaboratively on assessing current and future risks to safety, health and wellbeing. Anti-violence services have tended to focus mainly on the risks of violence, for obvious reasons. However, risks to safety are compounded and affected by many issues connected to the abuser, service systems in place, the presence of children, and to the woman herself (Agar 2003).

A worker may feel overwhelmed with the task of assessing risk when a woman presents with a complex history, multiple intersecting issues and current challenges to her well being. The first step is to assess her risk from others. Following the completion of a safety from violence assessment, the worker will continue listening to the woman's story and observing cues in her presentation, which could lead to further safe conversations regarding risk. If a woman disclosed a mental health issue or a worker picked up cues that one might exist, then the worker will begin assessing for safety regarding mental health concerns. If there is mention of past suicidal behaviour or the worker senses a deep hopelessness in the woman, then assessment for current suicidal ideation or behaviour would be appropriate. Similarly if a worker noticed evidence of injury to the woman's body, it would be appropriate to inquire whether self harm was a strategy with which she managed her feelings or stress and proceed with a safety assessment regarding this behaviour if needed. If substance use is disclosed, then we inquire about risk and strategies already in place for mitigating that risk. Although this may at first seem overwhelming, it is often quite natural to explore how a woman is coping with any issue she has, to discover what her strengths and strategies are surrounding it, and where she may be at risk. The title of this section is the importance of safe conversations, because it is how we imagine this work proceeding. Over several conversations, safely, following the woman's narrative.

There are empirically based assessment tools that focus on the abuser's risk for escalating violence (BC Institute Against Family Violence 2006; Campbell, Sharps and Glass 2001 in Agar 2003), and while there is evidence for the validity of several of these safety/risk assessment tools, the literature on this subject is clear that assessment tools cannot replace the clinical judgment and intuition of a service provider, or a woman's perception of the danger in her situation (Agar 2003).

This section of the tool kit provides the rationale for having conversations with women about their mental health or substance use concerns. It also explores the cautions that have been expressed concerning the use of universal assessment or screening approaches to talking to women about these issues. By presenting different arguments, options and examples, it is our hope that services and individual workers will feel better informed to make decisions about how to individualize assessment/safety planning tools into approaches they are comfortable with.

While there are natural interconnections between substance use and mental health problems that allow this section to attend to both issues, there are also many differences between the two areas in terms of how safety assessment has been approached thus far in anti-violence services. Mental health assessments seem to be better incorporated into our work than assessments concerning substance use, at least at a basic level. Asking about substance use has been more contentious, in part due to some services denying access to women who use substances. This kit is strongly advocating the inclusion of the impacts of substance use in safety planning and in overall counselling work. For agencies that have policies regarding women being under the influence of drugs and alcohol, this policy will need to be explored and evaluated.

There are three main parts to this section of the tool kit: the first deals with general issues concerning assessment for mental health and substance use in anti-violence services; the second examines the importance of having safe conversations about substance use; and the third describes tools that can be used to ask women about their mental health and mental health problems.

**T**he initial encounter is crucial in engaging a woman in services. The chief goal is to establish rapport: ask her what she needs and respect her answers. This may be as simple as providing reassurance that you will be there for her. Respect a woman's autonomy without judgment or argument.

### 3.1.2 Assessing Women For Substance Use And Mental Health Problems: The Debates

Routine assessment of mental health problems and/or substance use is a controversial issue in the anti-violence movement. Many anti-violence workers have a lack of trust in mental health and substance use services. Some advocates have expressed concern that conducting mental health assessments might alienate and further endanger abused women. They worry that assessments will lead to referrals to services that do not have an informed understanding of woman abuse in their medical or psychological assessments and interventions. Many in the movement view the mental health system as being pathologizing: by adding to the risks that abused women face (with diagnosis, medication, couples counselling, etc) and by failing to respond to the social underpinnings of abuse (Warshaw and Moroney 2002).

**D**efining our Terms: *Assessment* is the process of learning more about a woman and her situation in order to provide the most effective service we can. The process of *screening* is the questions we ask and conversations we have to determine whether a woman is eligible for our service.

In order for a woman to access mental health services, she needs a diagnosis; however, for an abused woman, just having a diagnosis may create a new danger. Psychiatric diagnoses are often used by batterers to "prove" that the violence is her fault, that she is "crazy," or that she is an unfit mother. Because both mental health problems and substance use are highly stigmatized, they are often used against women in child custody decisions by the legal and child welfare systems as well as by abusers (Warshaw and Moroney 2002). These are some of the reasons why some anti-violence workers choose not to complete formal assessments.

Overall, formal mental health assessment is not the norm in anti-violence services, since women are seeking services to address safety rather than their mental health or substance use concerns. But there are now many

working in anti-violence services who believe that substance use and mental health assessments can be very helpful as part of the work of helping women address the risks in their lives and increase their safety, support and general health and wellbeing. This view is connected to the belief that making substance use or mental health concerns visible should provide a woman with greater opportunities for more realistic and sensitive safety planning. If a woman has problems with substance use and is in a violent relationship she may be at risk of different or additional harms: physical, emotional, mental, financial and social. Discussing risks to safety can highlight areas of additional support she may require from your agency or from other agencies.

**A**ssessment should not be used to exclude women from your service. It should be used to improve advocacy, risk assessment and safety planning.

One of the most important questions that need to be raised regarding safety assessment is: what is our purpose in discussing substance use and mental health concerns with women? Other key questions include:

- Why do we want to assess for substance use? For example, are we assessing with a view to excluding certain women?
- What are we going to do with the answers? How will they assist us to help her?
- Are these women the ones we find most challenging to work with?
- Are we using assessment to reduce our own anxiety or increase our own comfort?

Another important issue to address early on is how we act on the information we receive. Safety or risk assessments can become bureaucratic exercises that have little value in practice. We need to use this information to provide women with the best support we can, individualized to her particular circumstances and needs. Of course sometimes she may just need us to listen attentively and compassionately to her story.

One main reason for having conversations about substance use and mental health is because women with substance use problems (very dependent on use) or debilitating mental health problems may find some of the trauma processing elements of counselling too demanding. A woman may only be able to engage in stage one stabilization and safety work (see Haskell 2003; McEvoy and Ziegler 2006).

### 3.1.3 Creating Safety In Our Conversations About Substance Use

*"The intervention is in the asking. When women are respectfully asked about both their use and their safety, they hear, even if they are not ready to listen or enact change immediately. Often women will later share comments such as, 'You know, when you said... it really made sense to me'" (Bland 2001).*

Many of us are uncomfortable talking about substance use. This can be for a number of reasons: lack of training, feelings of incompetence, personal experiences or beliefs. We may also fear "opening up a can of worms," or making a woman uncomfortable or angry. Because violence against women and substance use frequently occur together, discussing substance use is important. We therefore need to do what we can to get to a place where we are comfortable in addressing these issues with women. According to Bland (2001), the first requirement of respectful conversations about substance use is an honest evaluation of our own attitudes and beliefs about substance use, abuse and addiction. Training can help, so can talking with those with more experience in this area, peer support and supervision, or doing some reflective work such as that included in this resource kit (see section on Trauma, Mental Health, Substance Use within an Anti-Oppression Perspective). These can all help us to move our practice forward. Other things can also get in the way such as the perceived lack of time, lack of trust in other service providers or a lack of knowledge of community resources.

## Reflective Work

**D**raw up two lists of the hopes and fears you have about talking to women about their substance use. Now do one for talking to women about their mental health problems. How do the two lists compare? How many of these feelings get in the way of working alongside women on these issues? How may the hopes help your practice?

Discussing substance use must be done respectfully with a non-judgmental attitude. Whether you integrate questions about substance use in secondary intake forms, or use separate tools, women may well need to build up some trust with you before disclosing substance use or mental health problems: *information is unlikely to be given until it is perceived to be safe to do so*. It is therefore essential to establish a degree of rapport and trust with a woman before having these conversations. Additionally, careful consideration must be given to how information surrounding substance use is documented, particularly when using forms. It is recommended that agencies consult the Records Management Guidelines (2006) regarding intake forms and documentation when considering using any of the forms in Appendices 4, 6 and 7 in this kit. Many practitioners would advise not to ask questions about substance use in the initial encounter because of the danger of alienating women from your service (if she brings up the topic that is obviously different from you raising it).

If you decide not to have conversations about substance use at intake you may wish instead to be sensitive to any clues you may get that a woman has problems with her substance use. The following list is adapted from *Getting Safe and Sober: Real Tools You Can Use* by Alaska Network on Domestic Violence and Sexual Assault (2005) accessed at [www.accessingsafety.org](http://www.accessingsafety.org).

Cues indicative of substance misuse may include:

- The odour of alcohol on her breath
- Red eyes, pinpoint or dilated pupils
- Track marks on arms, hands or feet
- Inflamed, eroded nasal septum
- Rapid speech
- Difficulty tracking information
- Scratching and picking at arms or face during a visit
- Lethargy
- Nodding
- Cigarette burns (may also be indicative of violence or self harm)
- Prescription drug seeking behaviour
- Distorted perceptions

The reason for doing this is the evidence that shows that women who have these additional concerns are more at risk in many different ways and this should be an area of work you explore together at some stage.

**A**ssessment should be ongoing. Conversations about substance use and mental health do not happen once. As safety and trust deepen, women will reveal aspects of their experience that they previously were uncomfortable sharing.

We need to be aware that certain language and approaches to asking questions about sensitive topics can trigger trauma symptoms and emotional flooding, and can be experienced as very disempowering. Try to balance key questions with reflective statements to clarify and support the information being given. Always tell the woman why the information you are asking for is important and how you hope disclosure will help her. Women should be in control of what information they give, and in how much detail, so let her know that she can refuse to answer any questions, or answer them at a later point.

**W**orking collaboratively is the key. Without a respectful and collaborative approach underpinning our practice, all attempts to assess women for mental health or substance use problems risk further alienating women who are already vulnerable.

When opening conversations about substance use it can be helpful to lay some groundwork by using a general statement such as:

*A lot of women find themselves increasing their substance use when in crisis. We have a commitment to working with women with substance use problems here, so please feel welcome to talk about your substance use if you have concerns. This will not jeopardize your access to services. In fact it will make it more possible for us to be truly helpful to you as you make your plans from here.*

Wherever possible, seek to lessen the stigma associated with talking about substance use and support the woman to understand the connections between her substance use and the other aspects of her life, including experiences of violence, trauma and abuse. Convey the message that substance use and violence can happen to anyone. As described in the section Trauma, Mental Health and Substance Use within an Anti-Oppression Framework, substance use can have various meanings for women with trauma histories, often complex and unique to an individual. We should avoid making assumptions and spend time discussing how she sees the connections. If a woman talks about having problems with her substance use it may be useful to refer her to addictions services for a more comprehensive assessment as well.

If there are specific negative consequences to disclosing use of substances within your service, it is vital that these are presented to women clearly in advance, including the reasons for these consequences. Your service should have policies and procedures to ensure that her disclosure is not going to put her at greater risk or jeopardize her safety further. Policies on MCFD involvement also need to be clear. Look for ways to discuss with women the ways in which their use of substances might cause difficulties for themselves, the service and others. Risky behaviour involving children, and children being put at risk, is one example where confidentiality of discussions about substance use would need to be broken and MCFD may need to be informed (please see the section Empowering Strategies When Children are at Risk). Stating your responsibilities around child protection to a woman early on in discussions is therefore very important.

Discussing substance use must be done respectfully with a non-judgmental attitude.

**"O**verall, women's safety should remain the paramount concern. If there is need to consider excluding a woman from the service because of her behaviour when using substances, ensure she has other options for support/accommodation. It is important that she is not exposed to violence and other stresses due to her drug or alcohol use. Some anti-violence services, such as Kaushee's Place in Whitehorse, have a policy of accompanying women who arrive there under the influence to detox services, and providing reassurance that the door will be open when a woman is able to return, when not under the influence" (Poole and the Coalescing on Women and Substance Use Virtual Community 2007).

### Idea to try

**I**f you are thinking of introducing a new assessment tool, try it out with interested participants who come to your service. What do they like or not like? How could the tool be more friendly or woman-centered? When would it be best used? How could additional safety be built in?

When discussing substance use, informational materials on the health impact of drugs and alcohol can be useful to both service providers and women accessing services. The Alberta Alcohol and Drug Abuse Commission's Effects Series ([http://www.aadac.com/547\\_1430.asp](http://www.aadac.com/547_1430.asp)) and the Prima Project website (<http://www.addictionpregnancy.ca/substances/substances.html>) are both useful tools for this work.

**R**emember—no one expects you to be a drug and alcohol expert—you just need to be able and willing to have conversations with women about their substance use and relate these conversations to the risks women are exposed to, their safety and ongoing physical, mental, emotional and spiritual needs.

Different organizations may require different assessments or assessment approaches, depending on the level of support provided for clients. The first thing you need to establish is what level of detail you need in order to deliver your service. It may be that you will not need to know about amounts and types of substance use. It may be more important to set the stage by asking questions such as:

- Are you interested in discussing your substance use?
- Are you interested in exploring the connections between substance use and violence and trauma?
- Do you think your substance use is an issue for your safety or the safety of others?
- Do you think your substance use will affect you in court?
- We have a policy that women not be using substances on the day of coming for counselling or a group—will this be difficult for you?

The questions we listed in the Broadening the Lens and Moving Towards Empowerment section are also very relevant to our work on opening the conversation on substance use:

- How does your substance use affect your life?
- Does your partner use your substance use to harm or try to control you in any way? You may wish to give examples and see if any of these are going on for a woman...

- Controlling supply? Forcing you to use with him? Telling you he is abusing you because of your drug use? Stopping you attending services/groups/appointments? Undermining your recovery efforts? Threatening to report you to child protection services? Threats to inform police or immigration services? How do you cope with this?
- Does your substance use affect your safety? How? How do you try to keep safe? What support could help you with this?
- What strategies do you use to manage any negative impact? How well do these work?
- Are there any changes you would like to make in your substance use? Do you have ideas about how you can make these changes? How confident are you in making these changes? Would you like some help with making these changes? What do you think would help?
- Would you like any information about substance use? What information would help you?
- Would you like to receive additional support for your mental health or substance use? What kind of help would you most like? Do you have any concerns about using a specialist service? Is there anything I can do?

If your service is aiming to do more developed work with women around their substance use issues then more detailed questions may be appropriate. Questions like these may be helpful:

- Have you ever thought you should cut down on your drinking or drug taking?
- Do you get annoyed when people criticize your use?
- In the morning do you ever wake and regret something you have done the night before?
- Do you think your drinking or drug use causes problems with your family/your work/your health, etc?
- What substances are used and how much is used?
- How are the substances used? Separately or with other substances?
- When are the substances used; e.g. what time of day, with whom? Describe a typical day.
- What makes you start or stop using? (The Stella Project 2004)

These questions may help you assess a woman's need for more detailed and comprehensive intervention from specialist services. If the woman wants to discuss her substance use in a more in depth way you could ask whether she would consider being referred to a drug and alcohol service. Once she is established with a worker there, you may want to check in with her whether she would like to continue accessing anti-violence services while she focuses more specifically on her substance use issues. At any time when you have referred a woman to another service, it is preferable with her permission to share her safety plan with the other worker.

**"M**any anti-violence services work closely with substance use counselling services, inviting counsellors to make regular visits to establish relationships with women who may need support, and to demystify treatment and support options. Working together in this way also supports referrals to withdrawal management, harm reduction supports or addictions treatment, where necessary. Collaborative connections between service providers in anti-violence and substance use services models the connections that we hope that women will be able to make and draw upon" (Poole and the Coalescing on Women and Substance Use Virtual Community 2007).

We have included a standard intake form in Appendix 4 as an example to use to gather mental health and substance use information. The Records Management Guidelines (2006) recommend that a secondary intake form be utilized when a service provider is gathering more specialized and in-depth information in order to guide provision of appropriate service. Please refer to this resource for more guidance on documentation of sensitive information.

We have also included a handout in Appendix 5 called *Self-Report Checklist of Warning Signs: Do you have an alcohol or drug problem?* This is a checklist of some warning signs that may suggest an alcohol or other drug problem. It could be given to a woman to take away and consider before talking to her about her answers. It has been taken from a larger online resource called *What A Woman Should Know: Alcohol and Other Drugs* by the Alberta Alcohol and Drug Abuse Commission.

If your service requires more detailed substance use assessments, please see The Stella Project's *Domestic Violence, Drugs and Alcohol: Good Practice Guidelines* document (2004) for more information on possible assessment formats and questions (website is listed under resources at the end of this section).

### **3.1.4 Following Up: Ongoing Support Work With Women With Substance Use Concerns**

Our work obviously does not end with having the initial conversations. This is the beginning of the work. Other sections of this resource tool kit discuss ways of working with women who have substance use concerns (see the sections Broadening the Lens and Moving Towards Empowerment, Moving Towards Safety: Using a Harm Reduction Framework, and Safety Planning with Women Using Substances). The following guidance aims to help you to work with a woman after she has described having problems with her substance use and has given you permission to work with her on this. It has been taken and adapted from the BCASVACP Best Practices Manual by McEvoy and Ziegler (2006). While it aims to support counsellors, it is relevant to all anti-violence workers who are undertaking more in-depth work with women clients around their substance use.

- Support harm reduction by encouraging other healthy behaviours, such as eating and sleeping well.
- Ask how the substance helps her.
- Acknowledge the client's need for self-soothing, which the substance might be meeting. Discuss alternative means of self-soothing and tolerating painful memories and encourage her to practice these methods. Ask her to describe situations in which she has been able to use alternative methods (see Appendices 14, 17 and 19).
- Never meet resistance head-on. Certain kinds of reactions are likely to exacerbate resistance, back the woman further into a corner and elicit anti-motivational statements from her. Unhelpful counsellor responses include:
  - Arguing, disagreeing, challenging
  - Judging, criticizing, blaming
  - Warning of negative consequences
  - Seeking to persuade with logic or evidence
  - Interpreting or analyzing the reasons for resistance
  - Confronting with authority
  - Using sarcasm
- Try making some of the following motivational statements to your client.
  - I assume from what you've talked about that you have some concerns or difficulties related to your substance use. Tell me about those . . .
  - Tell me a little about your substance use. What do you like using? What's positive about using for you? What are the downsides of using?
  - Tell me what you've noticed about your using. How has it changed over time? What things have you noticed that concern you or that you think might become problems?
  - What have other people told you about your using? What are other people worked up about?
  - What makes you think you might need to make a change in your use?

- You don't think that \_\_\_\_\_ is harming you seriously now, and at the same time you are concerned that it might get out of hand for you later.
  - You really enjoy \_\_\_\_\_ and would hate to give it up, and you can also see that it is causing problems for you, your family, etc.
  - I appreciate you are hanging in there through this discussion, which must be hard to do.
- Encourage your client to try some of the following strategies to cut down her substance use:
    - Plan the substance use.
    - Set limits on the day, time and amount of use (e.g. only after 8:00 PM, only on weekends, etc.).
    - Try to have at least two substance-free days per week.
    - Delay the first use and each use after that.
    - Find something else to do as a distraction from wanting to use more.
    - Arrive at the dealer later than usual.
    - Leave the dealer earlier than usual.
    - Spend time with someone who will support your efforts to cut down.
    - Avoid situations where you are likely to use or where you use a lot.
    - Plan what days will be normal use and what days will be heavier use.
    - Prepare only a little of the substance at a time, even if you intend to use more.
    - Place the substance in a place that is hard to get to, or give it to someone who is supportive of your efforts to cut down.
    - Reduce your tolerance so you need less.
    - Keep a record of how much you are using and check whether you are meeting your goals.
    - Do not try to keep up to other people; go at your own pace.
    - Take only as much cash as you need when you go out, ensuring you have enough to get home.
    - Ask a support person to accompany you when you cash your social assistance cheques.
    - Leave your ATM card at home.
  - Suggest the following strategies for dealing with cravings (see Appendices 14-16):
    - Identify when the craving starts; knowing what is going on is the first step in doing something about it.
    - Remind yourself that cravings are a normal part of cutting down and that they will pass with time; the more you give into cravings, the stronger they become.
    - Remember that cravings are like a hungry cat: the more you feed it the more it comes back. If you don't feed it, the cat eventually stops coming back.
    - Try to find something to distract you, even if this only delays you from using the substance.
    - Try to learn when you are most likely to crave the substance—for example, in certain situations, with particular people, when you feel a certain way—and plan how you will deal with each situation when it comes up.
    - Delay using for an hour or even five minutes. When the time is up, delay for another hour, then another hour and so on. It is easier to resist cravings for a manageable period of time than to try to stop forever.
    - Talk to someone supportive when you start to get cravings.
    - Do something relaxing and enjoyable instead, like having a bath or a shower, having a massage or using aromatherapy products to induce relaxation.
    - If you are able, go for a walk or a run or do some other physical exercise.
    - Visit friends who don't use the substance or won't while you are there.
    - Watch a video or go to a movie.
    - Listen to relaxation tapes.

- Reward your efforts to cut down, even if you ended up using more than you meant to. It takes time to make a change and being hard on yourself will make it more difficult to change your habits.
- Talk to friends who have been able to cut down their use and find out what worked for them.
- Talk to friends about how they enjoy themselves or relax without drugs to get some ideas that might work for you.

**S**ome anti-violence agencies are experimenting with creating both formal and informal spaces where women can safely share their stories and learn about the connections between substance use, violence, poverty and other connecting factors. "Stitch and bitch" sessions at the Phoenix Transition House in Prince George are one example. Phoenix Transition House in Prince George, Haven Society in Nanaimo and Atira Women's Resource Society in the Vancouver area are offering meetings of the 16 Steps for Discovery and Empowerment groups (see Kasl 1995).

### 3.1.5 Why Talk About Mental Health Problems?

It is essential to gain as much information as possible about a woman's mental health and to do so in as empowering and as sensitive a way as possible. Mental health is an intrinsic aspect of our wellbeing and can easily become out of balance when we are stressed or in crisis.

**R**emember that mental health is on a continuum and is in a constant state of change.

There are many reasons why it is important to ask women about their mental health and their use of mental health services. One significant reason is that women who are living in violent relationships, who have trauma backgrounds, use substances or have mental health concerns, are at higher risk of being a danger to themselves than the general population. Suicide is a particular risk for this group of women, so we need to be asking the questions and being open to talking about self-harm and suicide in order to factor in these risks to safety, as well as looking at risks from others and other external risks.

Some anti-violence services will ask questions about mental health as part of their intake process, others as part of safety assessment or safety planning. It is advisable to ask women as soon as you can and while you are asking other questions, so that both questions about mental health and about substance use are normalized.

Doing a comprehensive assessment of a woman's mental health can help us to better direct our work with her. For example, we need to assess a woman's ability to be present with us to do advocacy, support and counselling work. Women with these intersecting concerns may benefit from support with education, advocacy, safety, stabilization, self-care, self-regulation, establishing boundaries and developing communication skills (McEvoy and Ziegler 2006). However, be wary about using blanket rules: some women with co-occurring problems may indeed be well suited for stage two trauma processing interventions within the STV Counselling framework. If in doubt, consult with your supervisor and ask the woman herself what she thinks, if this is appropriate. Your level of training, experience and access to good supervision will play a part in deciding whether this is an appropriate intervention.

**I**f a woman has mental health and/or significant substance use issues, be clear about the services you can offer without excluding her. Be aware that the effects of substances are similar to mental health symptoms and that mental health symptoms are often symptoms of living with violence. Do not attempt to be an expert—remember that the woman herself is the expert on her own situation and problems.

We also need to find out about any medications a woman is taking: prescribed drugs can have an impact on a woman's vulnerability and safety. The effects or side effects of medication can also be mistaken for effects of substance use or for mental health problems themselves.

If a woman has been diagnosed with a mental health problem it is likely that she will have been working with mental health professionals in the past and may still be. If this is the case, your agency should consider working closely with these agencies in an attempt to provide coordinated care and support. Inter-agency coordination can be very beneficial when a woman has many complex problems and needs many different kinds of supports (see Treatment Issues with Mental Health and Substance Use Problems).

Intervention by mental health services is difficult for many women. A woman who has been abused may have been described as "crazy" by her abuser. A referral to mental health services may confirm this verbal abuse and deepen her sense of disempowerment and loss of self-esteem (Humphreys and Thiara 2003). Many women are terrified of the stigma of using mental health services within their own communities: this may be seen as worse than not getting any help.

Keep this in mind when making referrals to these services and try to make referrals to places that are more likely to see the interconnectedness of the violence and the mental health problems. Try working more closely with the services that do exist to help them become more aware of the interconnectedness of these issues (see *handout we have created for use with other agencies and sectors: Making Connections: Women's Experience of Violence, Mental Health and Substance Use Problems in Appendix 3*).

### 3.1.6 Asking About Mental Health Problems

At the stage of intake take into account how a woman is presenting to you—as anxious, over-excitable, depressed and withdrawn, tearful... Ask yourself what this behaviour and her emotional state may indicate. How does her emotional state help you to know what kind of approach you will take with her?

The following behaviours *may* indicate that a woman has mental health problems or is in mental distress:

- Being emotionally high or low in ways that seem out of context
- Being very nervous, panicky or distrustful/suspicious/hostile, beyond the circumstance
- Being hyperactive, unable to sit still or concentrate or very impulsive and quick to act
- Being very inactive, withdrawn and slowed down, slow speech and movement
- Lacking coherence or clarity in speech—bizarre statements, incoherent ideas or hallucinations
- Inappropriate facial expressions for the context or situation, unusual gestures or postures
- Speech very speeded up and thoughts seem to be jumbled up
- Inability to remember things, to use judgment or problem solve
- Disorientation or dissociation
- Dress and appearance out of character or unusual or very poor hygiene

These must be used with a good degree of caution however: it is not your job to diagnose the women you work with, or to be a mental health expert. Many of these behaviours are common in women who do not have mental health problems—they can be related purely to the crisis situation they are in, or due to trauma symptoms, sleep deprivation, the consequences of legal or illegal substance use, or some kinds of brain injuries or disabilities.

Possible questions to ask:

- Have you ever been given a mental health diagnosis by a qualified mental health professional?
- Have you ever been hospitalized for a mental health-related illness?
- Have you ever harmed yourself or thought about harming yourself?

Other questions that could be asked when completing a more detailed *mental health risk assessment* include:

- How would you describe your current emotional state/state of mind?
- Do you ever think about committing suicide? Have you tried in the past? Do you think about it now? How would you go about it? Have you planned to do it?
- Have you ever been violent? Where is your violence directed?
- Do you ever think that people are talking about you or conspiring against you? (The Stella Project 2004)

We have placed a Risk and Significance Summary in Appendix 6 that can be used to summarize the risks a woman is currently facing. It has been adapted from a similar form by Fisher and Choquette (1999). It asks you to assess:

- 1) How serious a risk to safety does the issue pose?
- 2) How important does the woman see each of these issues as being?

The mental health and substance use safety assessment form in Appendix 7 has been adapted from The Stella Project's *Domestic Violence, Drugs and Alcohol: Good Practice Guidelines* (2004) and details a number of significant areas to ask women about and write up brief comments about. Risk to others is rare in this population of women: they are much more likely to be a risk to themselves. However, in determining risk it is considered, by organizations such as The Stella Project, to be safer to cover all areas with a woman as a standard approach in a sensitive and non-judgmental way so that she can give her own account of her risks and dangers. If a worker or agency chose to utilize an assessment form in order to document risk and work towards safety, it is recommended that the form be brought into your work with a woman once a relationship has been established. Workers need to remember to limit their information gathering to what is relevant in order to provide effective service to the woman, in this case a careful assessment of her safety, and to keep any note taking brief and factual. Workers may want to review the *Records Management Guidelines* published by the BCASVACP and BCYSTH, 2006 for more information on case notes and gathering information at intake.

### **3.1.7 Self-Harm And Suicide: The Differences And The Inter-Relationship**

The next two sections look at the risks of suicide and self-harm, as these are two of the main areas of concern for women with intersecting violence and mental health concerns and those that support them.

# Assessment of a woman's mental health can help us to better direct our work with her.

## Differences Between Suicide And Self-Harm

*Adapted from information by the UK National Self-Harm Network: [www.nshn.co.uk](http://www.nshn.co.uk)*

Self-harm represents a way of coping with very strong feelings of distress.  
Self-harm can be a way of preventing suicide.  
Self-harm is often a survival strategy.  
Self-harm can be used by women to restrain themselves from further damage.

Suicide and self-harm are fundamentally different and need to be treated this way by service providers. Self-harm is not suicidal behaviour. Self-harm is about trying to stay alive, despite the pain people are in. Many more people self-harm than kill themselves, and most people don't hurt themselves so badly as to risk their lives. Of those who do, suicide may not have been their intention; it is the feelings they want to wipe out (Understanding Self-Harm Booklet <http://www.mind.org.uk/Information/Booklets/Understanding/Understanding+self-harm.htm>). It may be a way to reduce tension that could result in an actual suicide attempt. Self-harm is often the best way a person knows to self-soothe and represents the best attempt to create the least damage. Having said this, suicide and self-harm do have a relationship: a diminishing sense of self-worth, that may have been partially dealt with through self-harm, may culminate in suicide eventually (National Self Harm Network [NHSN] 2007). Evidence from recent UK research shows that people who self-harm are at greater risk of going on to attempt suicide (NSHN 2007). Following an act of self-harm, the rate of suicide increases to between 50–100 times the rate in the general population (Hawton et al 2003 in the NICE Guidelines 2004). This may be due to a common root cause behind both expressions of distress: the experience of trauma and abuse, particularly from childhood.

The Centre for Suicide Prevention has a helpful fact sheet that differentiates between suicide and self-harm. See <http://www.suicideinfo.ca/csp/assets/alert43.pdf>.

### 3.1.8 Self-Harm

*"I was in pain and cut myself. I got labelled a manipulative borderline. But no one ever asked me how I felt. Being called manipulative felt like when my mother used to taunt me and called me a baby if I cried when she beat me" (Saakvitne et al 2002).*

Self-harm consists of self-inflicted injuries such as cutting, burning, head banging, bleaching, cheek biting, hair pulling, picking at skin, genital mutilation, failure to seek medical care and hitting oneself, walls or other hard objects. Eating disorders are sometimes included in the definition as well. For women in violent relationships the risks of self-harm are high: one third of all women attending emergency departments for self-harm were experiencing violence in their relationships. Childhood experiences of physical and sexual abuse are also closely linked to self-harming behaviour in adulthood (Conterio and Favazza 1986).

#### Some of the reasons women give for self-harm:

- To make me feel real — *counteracts dissociation*
- To punish me — *addresses or temporarily lessens guilt or shame*
- To stop me from feeling — *safety tactic when strong feelings are too dangerous*

- To mark my body — *to show externally the hidden internal scars of trauma*
- To let something bad out — *symbolic way to try to get rid of pain, shame or things that were put in the body during abuse*
- To remember — *to repeat some aspect of an abuse experience as a way to remember without knowing*
- To keep from hurting someone else — *or to control my behaviour and my anger*
- To communicate — *to let someone know how bad my pain is*
- To express anger indirectly — *to punish someone without them getting angry at me (Inequality Agenda 2005)*

Other people may react to a woman who self-harms with disgust, confusion and avoidance. Fearing this kind of reaction, those who self-harm may refrain from seeking medical attention for their injuries to avoid judgmental reactions from medical staff. It is essential that you respond to women who self-harm with compassion rather than judgment.

It is therefore useful to directly ask about self-harm when working with women so that it becomes normalized. For example, you could say that it is a common coping mechanism among women survivors of violence and trauma and ask her if that has ever been her experience. In doing so, you are setting the frame for discussions when she is ready. It also communicates your familiarity with the problem and your willingness to have an open discussion when she is ready (McEvoy and Ziegler 2006).

## What can be done to help?

**D**uring a recent study of people who have been able to stop self-abusing, the participants told us what helped them. Each participant had unique experiences but some very powerful lessons arise from the common themes identified.

### Hope

Self-abusive behaviour is supported by an environment in which people feel worthless, powerless and hopeless. They react to these feelings by lapsing into increasingly self-abusive behaviours and in the process alienate family, friends and professionals. *Hope for improvement and for control over their lives is the ingredient identified as most important in reducing and eventually discontinuing self-abuse.*

### Non-judgmental acceptance.

People who self-abuse are incredibly sensitive to the feelings of those around them. They are able to "pick up on" the frustration, anger and rejection of others. They expect this and are looking for it. People who will be able to help are those who are able to understand that self-abuse does not constitute a flaw of character but is a problem-solving device that soothes the painful feelings but makes life more difficult at the same time.

*Continues on next page*

### Companions on the journey.

Although it may not always be possible to supply people who self-abuse with the companionship of others who have had, and have defeated, a problem with self-abuse, it is essential that they see helpers as companions on a difficult journey and not as authority figures with power to control their lives. It is equally crucial that helpers see themselves in the same way.

### Understanding the behaviour.

Both helpers and clients need to accept the fact that self-abuse is soothing. It is also a way to maintain some sense of control over painful experiences and problems of living.

### Learning healthy ways of self-soothing.

Since people who self-injure have never learned how to soothe themselves in healthy ways, they need to be shown that a variety of strategies can be used effectively. They need to be helped to create a list of such strategies to use when urges to self-abuse come. When first introduced to this concept they will often resist, saying, "that doesn't work". They need to be encouraged to keep trying, to work through several of their strategies before they "give up" and self-abuse.

### Dealing with "trigger" events.

Raising to conscious awareness the cycle of response to a trigger event gives opportunities

- to discover what "triggers" the individual
- to challenge the cognitive distortions
- to identify and deal with the emotional reactions
- to formulate a variety of alternative strategies to deal with the trigger event
- to choose one of these alternatives and act on it.

Consistent use of this process will allow the person to feel more positive about their abilities to solve problems. They will feel stronger and more competent.

(Taken from: <http://www.safeincanada.ca/>)

For women with a history of trauma and/or current experiences of violence, assessment processes are needed to include her in (1) identifying specific circumstances that elicit potentially harmful behaviour, and (2) understanding what responses can help her de-escalate and feel safe (Carmen et al 1996). Because self-harm is a coping mechanism, the underlying causes will need to be identified before the self-harm behaviour can be successfully addressed. Focusing on the self-harm behaviour alone will not help a woman learn to cope with the underlying issues. Successful interventions help women learn new ways to express and articulate their emotions and needs, increase their tolerance for intense emotions, and recognize their triggers so that they can minimize, avoid or diffuse them.

Women should be in control of  
what information they give.

*Safety assessment of self-harming behaviours*  
(material provided by Susan Armstrong)

Assessing whether someone is placing their life or physical safety at risk through their self-harm behaviour requires a detailed understanding of the actual method of harm. In order to assess level of risk adequately, one should know the following:

1. Does the individual harm alone or with others? The presence of others increases the risk.
2. Is the individual using alcohol or drugs before or while harming?
3. Is the individual sharing instruments with others while harming?
4. Is the self-harming planned or impulsive? Risk increases with greater impulsivity.
5. Is there suicidal intent attached to the harming behaviour?
6. Is the individual dissociated while harming? Risk increases, the higher the level of dissociation.
7. Does the individual have a pattern of self-harming that has been escalating?
8. How does the individual care for his/her wounds?

We have also included another assessment for self-harm in Appendix 8 that has been taken from the Best Practices Manual (McEvoy and Ziegler 2006). There is a lot of additional material on self-harm and ways of supporting women who self-harm in this resource. Please also see end of this section for a list of resources, including web resources, on self-harm.

### 3.1.9 Suicide: The Warning Signs

*"I tried to take my life because he left me with no other way out" ("Jenny" in Humphreys and Thiara 2003).*

Thinking about killing oneself is an extreme solution to intolerable emotional pain and/or an intolerable situation. Survivors of childhood trauma experience high suicidal ideation.

**F**or women in violent relationships the risks are high: abused women are five times more likely to attempt suicide than non-abused women (Barron 2004).

Mental health problems are the common thread in all groups with a high risk of suicide: Ninety percent of people who die by suicide were experiencing depression, an addiction or other diagnosable disorder when they took their lives ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)). Ask your client questions about:

- Disrupted sleep patterns
- Lack of interest in usual activities
- Feelings of guilt, particularly survivor guilt
- Decreased energy, feeling like she is moving through molasses
- Inability to concentrate
- Disrupted eating patterns
- Suicidal thinking

**A**ll highly suicidal clients need to be brought to the attention of your manager/supervisor. Follow your agency's policy and/or your community suicide protocol on limits to confidentiality when a client is a high risk for suicide. Inform your client of the requirement that you disclose her level of risk to another person. Discuss with her how this disclosure may best support her and involve her in the disclosure.

Other warning signs your client may exhibit or tell you about include<sup>1</sup>:

- Hopelessness, helplessness, despair and loneliness
- Talking or writing about death, dying or suicide
- Rage, uncontrolled anger or thoughts of revenge
- Reckless or risky behaviour
- Feeling trapped, like there is no way out
- Increased substance use
- Telling you that she has obtained the means to hurt herself (e.g. has an extra refill of medication, has a knife)
- Withdrawal from friends, family and community
- Anxiety, agitation or panic
- Physical illness, chronic pain/disability or terminal illness
- Dramatic mood changes
- Writing a suicide note or completing a will
- Giving away prized possessions
- Feeling that she has no reason for living, no purpose in life
- No future orientation other than a preoccupation with death
- Comments such as: Sometimes I wonder if it's worth going on, All this won't matter soon anyway, I've made such a mess of things—my (partner/family/children) would be better off without me
- Sudden increase in energy and lifting of depression with no corresponding change in life circumstances: Your client could be relieved about having decided to kill herself. It may sound strange, but a person with depression may be most likely to attempt suicide just when he or she seems to have passed an episode's low point and be on the way to recovery. Experts believe there is an association between early recovery and increased likelihood of suicide. As depression begins to lift, a person's energy and planning capabilities may return before the suicidal thoughts disappear, enhancing the chances of an attempt.

You must directly ask your client specific questions, such as:

- Are you telling me that you are considering suicide?
- If yes, what method do you intend to use?
- Do you have access to the means? (e.g. stockpiling medications)
- How lethal is this method? (e.g. pills vs. a gun; means other than ingestion usually mean a higher level of lethality)
- Do you have a date, time and place in mind for your plan? (e.g. soon vs. sometime; using the garage or jumping off the balcony)

If you believe your client is contemplating suicide, consider using a suicidal assessment form (see the example of a Critical Incident Suicide form in Appendix 9). This will help you determine what level of care is needed.

<sup>1</sup> This list has been taken from the BCASVACP Best Practices Manual by McEvoy and Ziegler (2006).

Even a client with low risk requires some intervention. To fill out this chart, you will have to ask your client more questions, such as:

- Have you attempted suicide before (a high risk factor)?
- Has anyone in your family/friendship circle completed suicide?
- Have you recently experienced other losses? Is it an anniversary of a major loss?
- Has there been some other kind of precipitating crisis?
- Do you have a history of mental health concerns?<sup>2</sup>

We have also included guidance on preventing a suicide in Appendix 10. Many agencies have written protocols in place that workers are to follow when a client is suicidal. These protocols typically include a standardized assessment, critical incident form and referral protocol. Documentation of one's assessment of risk, what actions were taken to ensure safety, and if confidentiality was breached – to whom and whether the client was informed of the breach of confidentiality—is documented in the file. For more information on documentation when risk of suicide (or risk of harm to others) is present, consult the *Records Management Guidelines*, BCASVACP and BCYSTH, 2006.

Interventions with clients who have recently attempted suicide include the following:

- Remember that, for someone who has recently attempted suicide, there is a short window for you to intervene, since another, possibly more serious, attempt may follow. Ask your client to tell you, in her own words, what recently happened.
- Make definite plans for help, for additional referrals as necessary and for a future appointment (McEvoy and Ziegler 2006).

### 3.1.10 References, Resources And Further Reading

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### Selected Websites On Suicide

Alberta Alcohol and Drug Abuse Commission  
[www.aadac.com](http://www.aadac.com)

Canadian Association for Suicide Prevention  
[www.suicideprevention.ca](http://www.suicideprevention.ca)

Centre for Suicide Prevention  
[www.suicideinfo.ca](http://www.suicideinfo.ca)

Children, Youth and Families Education and Research Network  
[www.cyfernet.org](http://www.cyfernet.org)

Project Resilience  
[www.projectresilience.com](http://www.projectresilience.com)

Resiliency In Action  
[www.resiliency.com](http://www.resiliency.com)

Suicide Prevention and Information Centre, UBC Mental Health Evaluation and Community Consultation Unit  
[www.mheccu.ubc.ca](http://www.mheccu.ubc.ca)

### Selected Resources On Self- Harm

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Self Abuse Finally Ends website with information and resources  
<http://www.safeincanada.ca/>

[www.nch.org/self-harm](http://www.nch.org/self-harm) is a U.K. site that posts a guide to understanding and responding to self-injury called *Look beyond the Scars*.

[www.palace.net/llama/psych/injury.html](http://www.palace.net/llama/psych/injury.html) is a site that provides lots of information about self-harm. The site also hosts the "bodies under siege" e-mail support list.

A closer look at self harm factsheet from the Centre of Suicide Prevention:  
<http://www.suicideinfo.ca/csp/assets/alert43.pdf>.

MIND UK. 2007. Self-Harm Information Factsheet. Available at [www.mind.org.uk/Information](http://www.mind.org.uk/Information)

National Self Harm Network (UK based): [www.nshn.co.uk](http://www.nshn.co.uk)

<http://www.selfharm.net/>: Describes itself as "The most comprehensive source of self-injury information on the web. Includes definitions, explanations of why, etiology and demographics."

## 3.2 Safety Planning with Survivors of Violence

BY TESSA PARKES

### 3.2.1 Introduction

When a woman makes contact with an anti-violence service and discloses that her partner or ex-partner is abusing her, we should consider her a potential homicide until we know otherwise. In this way we keep ourselves alert to potential risks, and engage in a risk assessment/safety planning process as a very first step of intervention. We start the safety planning by assessing the risk of violence and strategizing about what she and relevant services can do to address it.

In order to increase the effectiveness of the safety planning process, we then shift our lens to consider the impact of mental health issues on her safety. A worker may want to imagine that second level of inquiry as being a transparency that is laid on top of the initial assessment of risks and safety planning from violence, so that both layers are visible at the same time.

The third transparency to superimpose on the assessment is substance use—including licit and illicit—and its possible impacts on her safety. By addressing all three issues, we are addressing a wider range of potential risks to her safety.

### 3.2.2 What Is Safety Assessment And Safety Planning?

Helping a woman move towards safety is one of the key tasks that anti-violence services perform. Safety assessment and planning should be focused on reducing the risk of violence, not predicting violence. Women who live with violence have to continually evaluate their risk. Safety planning makes this ongoing process more conscious and proactive, with clear steps to take to stay safe.

*"The woman herself is considered the best resource when safety planning and service providers should respect a woman's ability to choose the course of action best suited to her situation" (Agar 2003).*

In this chapter, we have incorporated information from the *Aid to Safety Assessment and Planning (ASAP) Manual* (BC Institute Against Family Violence [BCIFV] 2006; see end of section for ordering information). Workers would likely benefit from having their own copy to refer to. ASAP is based on the premise that *"a strategy for consistency in assessing the risk that the abuser poses and in planning for the woman's safety will increase women's safety overall."* The manual was developed with input from experts and practitioners working with women who have been abused, as well as an extensive literature review on violence risk assessment and victim safety planning.

ASAP provides a way to systematically consider many factors that affect a woman's safety, including the abuser, the woman's individual situation, her support network, and the level of the system's response. This systematic approach to safety assessment will guide the worker in assisting the woman to develop the best safety plan possible, uniquely tailored to her individual circumstances, needs and resources. As ASAP stresses, relationship abuse may have unique dynamics for a woman who is:

- Aboriginal
- An immigrant or refugee, especially where English is not her first language
- In a same sex relationship
- Affected by adult guardianship legislation
- Dependent on the abuser for care

ASAP suggests that anti-violence workers contact and seek the expertise of agencies that serve these diverse communities in these cases. The Manual itself provides some helpful material on safety assessment and planning with women in abusive same-sex relationships (ASAP Appendix A) and transgendered people in abusive relationships (ASAP Appendix B). ASAP Appendix C contains information about a range of relevant resources in BC.

### 3.2.3 Utilizing Safety Planning Tools

**S**afety plans can assist to reduce danger. They cannot provide absolute safety (BCIFV).

There are a number of safety planning tools available to support our work with women. It is assumed that each anti-violence service has its own version of a safety assessment and plan. If you are looking for a good base for your work, we recommend using ASAP and the BCASVACP safety-planning outline reproduced in Appendix 11.

*It is critical that documents like these are used in a way that acknowledges and builds on a woman's knowledge of her own unique situation. There are suggestions in this document that will work for some women, but might be unsafe or unrealistic for others. Equally important is the fact that a woman is likely doing things to keep herself/her children safe that are not included in this document.*

Survivors and anti-violence workers with extensive experience in safety planning advise that documents listing options for safety planning SHOULD NOT be used as checklists to be reviewed with a survivor. They should be used as a tool to assist you, the anti-violence worker, to consider a broad range of possibilities in assisting a woman to plan for her safety.

Risks associated with the use of safety planning checklists include:

- Survivors may decide that the worker is the expert because they have all the answers, and as a result doubt their own instincts and experiences. This has proven to be very dangerous.
- Survivors may decide the worker is not likely to be helpful to them because their situation doesn't exactly fit into the checklist.
- Survivors may decide the worker is not aware of the context of their lives and therefore not credible.
- Survivors may feel that they are not being treated like a unique people with unique experiences and knowledge.

Tip: Keep the safety-planning checklist in your head as you engage in conversations with a woman about safety planning. Then refer back to the checklist to see if there is anything important that you have forgotten. This creates a more flexible and relational approach, while making sure everything important is considered and addressed.

Consider the following before you start a safety assessment and safety planning process with a woman:

- Discuss the purpose of safety assessment with the woman and see if she wishes to take part.
- Clarify with the woman that her choices are paramount. She is free to have a safety plan or not, or to act upon the safety plan or not.
- Provide emotional support during and after the safety assessment and planning process.
- Explain the confidentiality of the information and the legal limits to confidentiality.
- Collect only the information you need to plan for the woman's safety.
- Provide choices about whether the safety plan is written down, and, if the woman is taking it with her, how she will keep it safe from the abuser (BCIFV).

**A**woman's strengths, opportunities and supports need to be identified with her, as well as her risks and vulnerabilities. As service providers we need to be able to allow women the space to learn from mistakes and go at their own pace in creating more safety in their lives.

### 3.2.4 Gathering The Information: Focusing On Abuser Factors And Safety Support Factors

ASAP suggests that safety assessments focus on two sets of factors: *abuser factors* and *safety support* factors. These factors are listed in Part Two of the ASAP Manual. We reproduce them here for your information and guidance, but refer you to the whole document, which provides much more important detail that will help you through the process.

#### *Abuser Factors*

- Abuser's violence
- Violent threats, ideation, intent
- Escalation of physical/sexual violence or threats
- Violations of civil and criminal court orders
- Negative attitudes
- Other criminality
- Response to shifts in power and control dynamics
- Employment or financial problems
- Substance use
- Mental health problems
- Other considerations, i.e. significant life changes, access to weapons, current emotional crisis, coping with chronic pain, trained in combat or military service, etc.

Helping a woman move towards safety is one of the key tasks that anti-violence services perform.

### *Safety Support factors*

- Level of personal support
- Living situation
- Level of fear
- Barriers created by attitudes or beliefs
- Health impacts of the abuse
- Employment or financial concerns
- Child-related concerns
- Substance use
- Access to services
- Responsiveness of services
- Provision of information
- Coordination of services

Safety assessment involves identifying the presence and relevance of these factors. There is research evidence on the links between these factors and the increased risk of violence (this evidence is detailed in the ASAP Manual).

Review with the woman whether or not each of the factors listed above is present. If there is no information on a particular factor, think about ways to gather more information. Then consider the relevance of each of the factors and determine whether the factor decreases or increases a woman's safety.

**G**ather the information in a way that is respectful of a woman's Aboriginal identity, immigrant or refugee status, age, disability, geographic location, sexual orientation or gender identity.

As well as using the ASAP documentation, well-designed intake forms can provide us with an opportunity to gather relevant information to determine whether or not a woman is currently at risk from another person (or of harm to herself). Secondary intake forms may include information about a woman's physical, mental and emotional health (see *The Importance of Safe Conversations: Identifying Risk and Resources* and Appendices 3-9 for suggested intake forms and risk assessment tools). Remember that discussions about safety or risk assessment related to mental health and substance use may need to be left until a relationship has been established. Drawing out too much information early on in an intake process may be overwhelming for both the worker and the woman.

### **The Safety Planning Process**

The safety assessment process is followed by an evaluation of a woman's options for managing her risk, culminating in the creation of a safety plan. Safety plans include strategies for escaping, avoiding and surviving the violence, and strategies for increasing the resources and support available to her (Agar2003). Assessment and planning should help women to identify patterns of escalation (internal factors as well as external ones) and early cues for escalation.

### **Questions To Ask Women**

**A**re there ways that you know things are building up to violence? What are some of those signs?

The critical times when risk is heightened:

- Immediately following disclosure of the abuse to an outside party
- After the accused is interviewed by police
- When accused is released by police
- During charging process
- During plea discussion
- If stay of proceedings is entered
- Upon application for peace bond or other protection order
- Upon application to vary protection order conditions
- When accused is released on interim conditions
- When she initiates legal actions such as
  - Divorce
  - Custody or access
  - Property settlement
- When any papers are served, such as
  - Restraining Orders
  - Notification of Divorce or Separation Proceedings
- When she enters another relationship
- When the abuser loses control in other areas of their life

**T**he processes of safety assessment and safety planning need to be dynamic, because risk factors will change. Women should be helped to evaluate changes in risk and modify their safety plans accordingly. Some questions that could be asked to help this process are:

- Has anything changed since we last spoke that might affect your safety?
- When you thought about the plan this past week, did you think that any parts of it might be difficult to put into action? Is this because something in your situation has changed?

Most experts suggest discussing with the woman the strategies that have been used in the past and what strategies she is currently using. Many also suggest discussing the strategies that agencies and services have used to try to support her. Ask her how helpful these have been and what barriers she experienced. The new safety plan that you develop together should build on these past and previous strategies.

Help the woman to develop strategies for the future based on the abuser factors, safety support factors and the protective measures available. These can include:

- Making a police report
- Obtaining a protection order
- Ensuring that supervision measures in place for the abuser are being implemented
- Interventions for the abuser, e.g. mandatory drug testing while on probation, removal of weapons, abusive partner's treatment, etc.
- Woman's physical security, e.g. cell phone, safe housing, alarm system, etc.
- Woman's well-being, e.g. accessing support network, meeting her health needs etc.

Discuss the documentation and use of the safety plan.

## Priority Actions And Next Steps

This phase is an important next step and involves the following considerations:

- **Case prioritization**—note the level of effort or intervention that will be required to protect the safety of the woman or her children and other family members.
- **Serious physical harm**—note the risk that the abuser will engage in serious physical harm against the woman or her children and other family members.
- **Immediate action required**—note if immediate action is required.
- **Case review**—note when a safety plan should be scheduled for review. Set a date for a routine review and discuss with the woman what circumstances should trigger a special review. The safety plan should be revisited when there are important changes that might signal that the risk of an abuser's violence towards the woman is increasing.

Plans can be short-term or longer term and relate to, for example, a particular crisis situation, continuing to live with an abuser, leaving the abuser, continuing to have contact with an abuser while living apart, or a permanent separation (Davies et al 1998 in Agar 2003). For many abused women, the most dangerous period is in the 18 months after leaving the relationship. It is important for both the woman and the worker to revisit the safety plan regularly, even if there seems to be no immediate safety concern.

Studies demonstrate that family separation increases the risk of violence and homicide:

- In 1999, 40% of women who reported experiencing spousal assault by a past partner indicated that the violence occurred after the couple separated.
- A recent survey found that nearly one in five separated wives were assaulted while they were separated, and of those women, 35% reported that their husbands became more violent after the separation (Federal/Provincial/Territorial Ministers Responsible for the Status of Women 2002).
- Murder of a female partner is most likely to occur in the context of marital separation or divorce (Daly and Wilson 1999).
- Between 1974 and 2004, in Canada, the rate of spousal homicide against females has been three to five times higher than the rate of male spousal homicide. In half of all cases the woman was killed within two months of leaving the relationship (Department of Justice Canada).

Questions to Ask If Fear of Partner is Expressed and Only Contact is By Phone

- Are you in a safe place now?
- Are you injured in any way?
- Where is the person who hurt you now?
- Does the abuser have access to weapons?
- Can you tell me a little more about your concerns for your safety?
- Where are your children?

## Improving Safety When A Woman Is Staying In An Abusive Relationship

If a woman chooses to stay with or continues to have contact with the abuser there are a number of ways that she can try to reduce harm to herself and any dependents. The suggestions below have been taken from the safety planning resource by Agar (2003).

- If she is separated but still in contact, then telephone contact is safer than face-to-face encounters.
- A woman may choose to leave temporarily if the violence escalates or to emphasize that she is serious about the violence ending.
- A woman should be supported to protect the privacy of her communication so that she can continue to safety plan without the abuser's knowledge (e.g. getting a cell phone and adding "password voice mail").
- Explore with a woman the ways that she can minimize injury and get help during an assault by thinking about her environment, support mechanisms and other factors.

## Different Kinds Of Safety

### *External:*

External threats to safety may include violence and abuse from others, situational factors such as the existence of firearms in the home, involvement in the drug trade or organized crime, and immediate high-risk living situations such as compromised housing, high risk child care circumstances and inadequate financial support (Fisher and Choquette 1999). Safety assessments should therefore also address social and environmental circumstances as well as interpersonal violence.

### *Internal:*

Threats to safety may also come from internal factors such as suicide risk and severe depression, psychotic symptoms, disabling levels of anxiety and/or PTSD symptoms, severe eating problems, substance use and serious physical conditions that require immediate medical attention (e.g. diabetes, heart condition) (Fisher and Choquette 1999). Some of these internal factors will be created by behaviours of the woman.

Good safety planning requires a frank dialogue with women about their perceptions of their own risky behaviours. This should be tied to a discussion about the function of these behaviours; for example, how substance use or self-harm might assist in regulating her emotional state. Identifying the potential consequences is also vital, along with preventive strategies and crisis actions to take if the behaviours do occur. A more in-depth discussion on potential threats to safety from internal factors is contained in the next sections on safety planning with women who have mental health and/or substance use problems.

## 3.2.5 Extra Considerations For Safety Planning

Some women will require extra considerations and additions to their safety plans due to their culture, language, ability and/or other factors. For example, women who are disabled may be particularly at risk due to their increased physical reliance on an abuser (Nosek and Howland 1999 in Agar 2003). Particularly vulnerable groups are women who:

- Have a disability (physical or mental)
- Cannot effectively communicate in English
- Are living in isolated communities (geographical or social)
- Have insecure immigration status
- Do not work outside the home
- Are pregnant
- Are engaged in survival sex work

Ask women whether they have special needs for additional assistance that need to be accommodated in their safety plans. These may not be obvious to you as her supporter. Some examples are included below.

**Disability:** If I cannot leave my home because of disabilities I will contact

---

to make arrangements for transport when my partner is not there.

**Language:** I do not feel comfortable speaking English so I will ask

---

to translate or help me find someone to talk to in another language.

Taken from *Many Faces of Violence: Safety Plan* at <http://mfv.ca/>.

**R**isks will be present for women and children in violent relationships. Pets are also vulnerable to being harmed or killed and a plan for their safety, as well as the children's, can be highlighted in a safety assessment and plan.

### Coordinating Our Work

The ideal situation in supporting women with their safety assessments and safety plans is for us to be working with other agencies to ensure women do not fall through the cracks, while also ensuring the confidentiality and safety of women's information and their right to privacy.

### 3.2.6 References, Resources And Further Reading

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Ministry of Attorney General. 1992. *Wife Assault: Violence against women in relationships: Victim service worker's handbook*. Victoria, BC: Author.

Seeking Safety

[www.seekingsafety.org](http://www.seekingsafety.org)

Excellent site for information about this model of integrated treatment for trauma and substance use by Lisa Najavits. Downloadable articles on a wide range of Seeking Safety applications, about training opportunities and more. Useful materials on developing strategies for internal safety.

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# 3.3 Safety Planning for Women With Mental Health Issues

BY TESSA PARKES

## 3.3.1 Introduction

*"He kept telling me I was the one who was insane, and that I was always going to be that way as long as I used the drugs. So it was my fault that I made him angry. When I would really get into the crack I would get to the point where I'd get suicidal. And then it was him not being able to cope with my mood changes and stuff like that"*  
(Woman survivor in Edmund and Bland 2006).

As described in other sections of this toolkit, mental health problems such as depression, suicide attempts and self harm are frequently symptoms of abuse and need to be addressed in safety planning alongside issues of substance use and violence against women. Sometimes the psychological impact of being abused can lead to the development of significant mental health problems that may interfere with a woman's decision making ability (Agar 2003). For women with trauma histories, the risk of developing mental health problems in response is heightened. Pre-existing mental health problems can also be exacerbated by abuse and violence, for example through having medication routines interfered with, increased stress, or being unable to maintain wellbeing through preventive activities and attending supportive appointments (Jenkins and Davidson 2001 in Agar 2003).

This section of the toolkit is focused on safety planning when mental health issues are present. It has been written to complement and be complemented by the section Safety Planning with Survivors of Violence. As stated earlier, workers are expected to start any safety planning process with one focused on violence and then to add the lens of mental health and substance use when applicable to ensure that all impacts to safety have been addressed.

## 3.3.2 Connecting The Experience Of Living With Violence And Mental Health Problems

When women in violent relationships have mental health problems, abusers may attempt to exploit the woman's vulnerability or limitations around her mental health problem. They may do this in the following ways:

- Humiliate her by telling people of her mental health diagnosis
- Minimize or deny abuse by telling her she is imagining it or hallucinating
- Threaten to have her institutionalized if she reports the abuse
- Prevent her from getting help for her symptoms
- Keep medications from her, give her too much medication, demand that she takes medication
- Take advantage of the changes in her symptoms and moods by, for example, deepening suicidal feelings by encouraging them
- Threaten to take her children away and tell child protection authorities or the court of her illness

- Give false information to medical and psychiatric professionals, resulting in wrongful diagnosis/commitment/medication
- Convince her that she doesn't deserve to be, or won't ever be, in another relationship because of her mental health problem/disability
- Claim that she is an unfit mother because of her mental health problem/disability
- Minimize her credibility to police or other concerned parties by playing into stereotypes that people with mental health problems/disabilities are not credible (www.accessingsafety.org).

There are obviously many implications in the above for safety assessment and safety planning with a woman. If any of these are being experienced by a woman they should be flagged in her safety plan with potential strategies that you both can think of that may work to keep her safe or safer. The strategies will need to be individualized and appropriate to the dynamics that are occurring.

There are also other factors that increase the risk for women who experience mental health problems: ones that are connected to wider societal views about people with these kinds of problems. The socialization of those with mental health problems to be compliant with people with more power than them can lead to additional dangers, for example. This is particularly likely for women who have been institutionalized for extensive periods of time, but even spending short amounts of time in hospital can have a detrimental effect on how we perceive our own authority and autonomous sense of self. In mental health services, the most important decisions concerning a woman's treatment will be made by professionals, including, for example, if a woman is safe to be discharged or what medication she should be on. Women with a history of psychiatric treatment, and in particular of institutionalization, may utilize compliance as a survival strategy. This way of being with professionals may extend to workers in the anti-violence field and also may be acted out in her intimate relationship.

Negative public attitudes about disabilities in general, and mental health problems specifically, make women vulnerable in a number of other ways. Sometimes women with mental health problems are viewed as attention seeking, out of touch with reality, lying and manipulative: by those in society at large and unfortunately sometimes by those who work in health and social services. Being labelled or diagnosed with mental health problems can have serious ramifications on her self-esteem and on issues such as child custody, her ability to access resources, to make a police report of violence and/or to be perceived by a court as a credible witness.

### 3.3.3 Managing Overwhelming Feelings: How Abused Women Cope

When considering women's safety and making connections between safety, trauma and mental health, it is important to revisit the ways that trauma from the past makes a woman more vulnerable to certain emotional and mental states. Consider this question: How do the women you work with manage powerful and overwhelming feelings like: rage, despair, neediness, hurt, disappointment and love? Some of the strategies you thought of may include:

- Switching off—dissociation
- Depression and blankness
- Self-harming
- Obsessive routines and rituals
- Food—over or under eating, vomiting
- Self-medicating with alcohol or drugs
- Anger—suppressed or explosive
- Frantic efforts to distract themselves—e.g. through talking
- Acts of rebellion—criminal activity (Inequality Agenda, 2005)

Women's symptoms and behaviours, such as the ones above, can be viewed as adaptive: as ways of coping. Instead of just focusing on or treating the symptoms it is important that we look at:

- How do these make sense for her?
- How do they help her?
- How can we help her make the changes she wants?
- What does she need in order to cope without these symptoms and behaviours?

Ways that women reduce risks to themselves include:

- Appearing or being compliant
- Concealing or blocking emotional expression
- Keeping others at a distance
- Adopting the abuser's way of describing the abuse
- Trying to help or fix the abuser
- Keeping quiet
- Maintaining loyalty to the abuser
- Avoiding tenderness (Inequality Agenda 2005)

Once the distress and the behaviours of women we find difficult or challenging are contextualized it becomes evident that they are adaptations closely linked to their struggle to survive. However, while these ways of coping may seem to work for a while, they may also create new dangers. For example, these coping strategies may work to further isolate and distance her from other safe people, or she may begin to think she is responsible for the violence, or they may lead to her avoiding seeking help.

### Reflective Question

**H**ow can I support a woman in viewing her behaviours as safety enhancing and invite her to see potential future risks?

### 3.3.4 Identifying And Responding To Warning Signs, Cues And Triggers

The work by Lisa Najavits (2002) and Peter Levine (2005) can be very helpful in guiding our work in this area of trauma, survival and coping strategies. Their work describes many of the potential struggles for trauma survivors with just getting through ordinary life, coping with the past, and dealing with the often associated substance use and mental health consequences of the trauma. Their materials can be helpful to share with women who have had these experiences, to help them make sense of their own internal worlds and the reasons why they are caught in many traps of negative and stressful emotional and cognitive states. Cowichan Women Against Violence use some extracts from Peter Levine's work *Healing Trauma* (2005) and Lori Haskell's work *First Stage Trauma Treatment: A guide for mental health professionals working with women* (2003) to share with women trauma survivors. Many find the information incredibly useful and comforting as they realize they are not "crazy" after all and are not alone (Increasing Control and Dissociation and Self-awareness in Appendices 11 and 12 are extracts from Haskell's book).

Most of us get cues or warning signs that we are moving into distressed states and with experience we can learn to initiate some preventive strategies that can help us to stay more balanced and in control in these moments. This takes a lot of work and is not easy to do: it is much easier to keep going in our old circles or patterns. It is especially hard to do for those people who are recovering from trauma or who are living in fearful and unsafe situations. Some of the resources produced by the Victoria Women's Sexual Assault Centre

(VWSAC), and based in part on the Seeking Safety model by Najavits (2002), suggest the following ways of helping to keep safe and prevent relapse (this term is used mostly to indicate relapse into substance use but can be expanded to include relapse into experiencing mental health symptoms) and emotional breakdown.

- Helping women to recognize the warning signs of building distress and the triggers to using substances or to being overcome by trauma/other mental health symptoms. Possible questions include: What signs appear when you are starting to show distress? What feelings make you overwhelmed and scared? What situations or people can make you feel anxious/distressed/ threatened/uneasy/in need of substances/like cutting yourself? The Relapse Prevention handout in Appendix 14 can help you to work through this systematically with a woman. This exploration can help women to decide on strategies to use before the situation builds up to crisis (see Key Points about Red and Green Flags and Signs of Danger versus Safety in Appendix 15, and Create a Safety Plan in Appendix 16).
- Staying safe internally and avoiding relapse involves identifying people, places, situations and feelings that can lead to distress and relapse and making choices about what different actions to take when faced with these triggers and challenges. Part of the work with women will be to help them to begin to detach from unsafe people and move towards safe positive people. It will also involve choosing safe positive activities to get involved with when feeling stressed or distressed to try to avert crisis (See Safe Coping Skills in Appendix 17). Generally this work will involve increasing the control a woman has in her day-to-day life so that she has more opportunity to stay away from her triggers or risky things, people and places (see Coping with Triggers in Appendix 18).
- Strategies to help with self-soothing when distressed, tools to manage stress such as relaxation techniques and ways of combating mean self-talk and responding to oneself with compassion rather than blame and guilt (for strategies you could share with women see [http://www.dbtselfhelp.com/html/dt\\_handout\\_1.html](http://www.dbtselfhelp.com/html/dt_handout_1.html) or [http://www.psyke.org/coping/self\\_soothing/](http://www.psyke.org/coping/self_soothing/)).
- The importance of reaching out for help to safe others and the need to rehearse this because of women survivor's tendency to isolate themselves and hide away when things get tough, identifying key safe supportive people who can be available in times of stress/distress/crisis.
- Using techniques for detaching from physical pain, staying in the present and focused on the here and now, such as grounding (see Appendix 19, Using Grounding).
- It is also important for the woman to have a written safety plan for herself that includes these strategies and techniques (see Additions to Safety Plan for Women with Mental Health Concerns in Appendix 20).

### 3.3.5 Creating Safety And Containment

BY CATHY WELCH

Helping women to develop strategies for containment and internal safety is key in managing intense feelings and finding ways to stay present and grounded. These include techniques commonly used in the containment of traumatic memories, affect regulation, and creating safety through grounding. Like any new skill, practice is important. Learning new skills is one thing, being able to use those skills in times of intense arousal or when triggered is something else altogether. Practicing on a daily basis, in times of relative calm, may prove invaluable in times when stress levels rise. Helping a woman find ways to contain overwhelming emotions and to develop a sense of inner safety is important no matter what our work with her is. Even if our only involvement with her is to support her in going to court, providing her with containment and grounding skills can be essential in managing her anxiety levels, and thus her capacity to be present and effective in court.

Creating a sense of safety and containment involves three components:

- developing a container;
- developing a safe place or natural state of calmness; and
- grounding techniques.

### Developing a Container

Building a container is often the first step in developing a sense of inner safety and control and often is used in closing down after an initial assessment, which may bring up strong emotion, trigger memories or open a woman up in the telling of her story or at the end of a session. A script to use with clients in developing a container can be found in Lori Haskell's book *First Stage Trauma Treatment* (2003). The development of a container is also essential in the effective management of strong emotions. A container can be any mental image of a container that a woman wants. It needs to be strong enough to hold all her disturbing images, thoughts, feelings, and sensations, have a lid, door etc. that can be locked down, and needs to have a "one-way valve" where new material can be put in without opening the whole container, and a "spigot" where material can be let out in small amounts when she is ready. A strategy that may be helpful is to ask clients to begin to practice using their container on a daily basis, starting by putting any unresolved material, images, emotions or thoughts in the container before going to sleep each night and again in the morning before they start their day (in case anything leaked out in the night). Remind them that they do not need to look at what goes into the container, as that can be re-traumatizing.

### Developing a Sense of Safety or Inner Calmness

Again, there is a script for developing a safe place with clients in Lori Haskell's book. Helping women to develop a sense of internal safety, and to feel what that feels like in her body, is another key element in our work. Finding a safe place may be difficult for someone for whom no place was safe. If this is the case it may be useful to ask the client to describe an image that represents feelings of calmness and to focus on where she feels that in her body.

### Grounding Techniques

Grounding techniques strive to reconnect us to the present, orient us to the here and now and connect us to our bodies and a sense of personal control. Grounding techniques use both the awareness of physical sensations and cognition. Some examples of sensory awareness include getting people to connect with the ground by placing both feet on the floor, feeling the chair they are sitting in, becoming aware of what that feels like, or trying to pay attention to and take in their surroundings. Examples of cognitive awareness include knowing where one is, what day it is, what season it is, and what is happening in the moment (Haskell, 2003; and see *Using Grounding* in Appendix 19).

### Affect Management Techniques

Regulating the intensity of emotions requires skills in containment, modulating emotion, identifying feelings, and being mindful. Some strategies for modulating emotion include dimmer switch, remote control, videotape or audiotape, etc. For more information see *Increasing Control Over Your Feelings* Appendix 12. Teaching relaxation, breathing and mindfulness skills is also useful. As well, encouraging women to engage in regular exercise is important in building the capacity to regulate emotion.

One technique that is easy to learn is the Emotional Freedom Technique (EFT). This technique was developed by Gary Craig and more information can be accessed at [www.emofree.com](http://www.emofree.com). EFT uses acupressure points on the head and upper chest to tap into the energy meridians of the body to release any blockages. Many women have found this to be very effective in dissipating strong emotions, negative self-talk, physical pain and numerous other disturbances. It is well worth checking out the website above and learning the technique to pass on to clients. There you will find a link to a free, downloadable manual that explains the process of EFT.

### 3.3.6 Safety Planning When Mental Health Issues Are Present

**H**aving a mental health problem does not preclude a woman from making accurate assessments about her own risk. Agar (2003) suggests that a woman's mental health should only be considered a risk factor if she has problems that interfere with her ability to protect herself.

*"Safety means different things to different people. You will need to discuss with your client what it means to her. Never assume it will match what you think. For example, to you, safety planning may mean giving up self-injuring behaviour, but to the client, safety may come from cutting because it helps avoid intolerable feelings and terrible memories. It is important to define safety together. What does safety mean to her? Has she ever felt safe?" (McEvoy and Ziegler 2006).*

You and your client have different experiences around safety and this will affect your assessments of risk and danger, and of the necessary interventions. If a woman has never lived with safety then the concept of safety is obviously extremely difficult to engage in. It is only through incrementally moving towards safety that she can begin to discover what safety is.

So the goal of safety planning is to create more awareness for a woman and her supporters on the dynamics of her mental health. This can be done through sensitive discussion with a woman that identifies:

- what triggers intense and difficult feelings
- what makes her feel worse
- what helps
- who helps

This can be very helpful both for her and for other key supports in her life that she may like to share this information with. A preventive plan of action can then be put together which clearly indicates what the woman can do herself, when she gets warning signs, and who/what else in a woman's life, such as professionals and informal supports, can assist her. This would be particularly important if a woman is feeling suicidal.

**K**ey supportive people in the woman's life need to be identified in a safety plan, people who she can go to or talk to if she should feel desperate and suicidal.

Emergency contact numbers for mental health or other support professionals need to be clearly marked in the safety plan. It would be important to consider who is available to the women during evenings, night time and early mornings as well as daytime hours because these are likely to be the times when she most needs help and when there are fewer supports available to her. Help her to also identify what action she will take to maintain her safety when she cannot locate a support person.

**W**e need to remember to focus on strengths as well as vulnerabilities when discussing safety.

Support a woman to explore and recognize specific vulnerabilities such as her own triggers for becoming unwell or distressed (escalating violence at home, demands at work, problems with children, painful anniversaries, child custody issues; see Appendix 15, Signs of Danger versus Safety). Below is an additional script you could add to your safety-planning template that specifically addresses mental health issues.

If mental health issues occur alongside violence in my relationship with my partner, I can enhance my safety by doing some or all of the following:

I will remind myself that violence affects my stress levels and impairs my mental health so when I am in violent situations I need to be more watchful of my stress and mental health needs. I will ask for help from

---

The following events almost always increase my stress and have a negative affect on my mental wellbeing

---

The warning signs that I am getting stressed and moving into crisis are

---

and this is what I will do in these situations to try to keep myself well/balanced and to try to keep myself safe

---

If I feel myself moving into a crisis state I can

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I can also

---

I can call \_\_\_\_\_ for support when I feel emotionally distressed

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The following people/places/things can be unsafe for me

---

To safeguard my children I might

---

Other things I can do to help me feel stronger are

---

If there are additional supports you require for your mental health or substance use problem such as numbers of supportive professionals or advocates or medication then make sure these are stored with other important documents and items that you can take with you in crisis situations when you need to leave your home quickly.

Keep an extra supply of medication alongside other critical items with a trusted friend or in a concealed place, easily accessible if you need to leave quickly.

Think about:

- Medications and prescriptions
- Information about services and benefits
- Names and phone numbers for case workers or other service providers that can help to coordinate services for you
- Health/life insurance papers
- Medical records

Please see Appendix 20 for a handout of this to share with women.

### **3.3.7 Safety Planning And Possible Impact of Medications**

Women with mental health problems in violent relationships are highly likely to be taking prescribed medication and this therefore needs to be considered when assessing safety and safety planning.

Over-prescription of psychotropic drugs can provide problems for a woman's safety in a number of ways:

- Sometimes even moderate amounts of medication can make women feel sedated and lethargic and this can affect their safety, including making it harder to concentrate, make decisions, think quickly, or be aware of the escalation of violence.
- Abusers can deny women's access to medication or divert their medication for their own use.
- Women leaving abusive relationships may be unable to bring their medications with them, which can increase risk in some situations where regular medication is needed (to prevent very unpleasant side effects of other medications, for example).
- Medical emergencies can result in some situations.
- Mixing medications and other substances such as alcohol can also be dangerous (particularly in the case of barbiturates).

Help a woman explore the benefits and drawbacks to her medication use; for example, is she getting enough benefits from it to counterbalance the risks it may pose?

If a woman is only experiencing negative effects and is not aware of any positive effects then this needs to be raised with her physician or psychiatrist/mental health team: ideally you could facilitate this if she was happy for you to do so. Advocate for a review of the medication, citing safety as your main concern. You need to stress that a woman needs to still be able to act to protect herself and her dependents from harm despite having mental health needs. Be wary of coming across as purely anti-medication as this is unlikely to get a positive response. If you can clearly evidence your concerns and the impact of medication on her safety this should help mental health professionals and family physicians work with the woman to get a better balance.

### **3.3.8 The Mental Health Act And Nearest Relative**

Under mental health legislation a nearest relative can be called upon to make decisions in a person's best interests if they are deemed to be lacking capacity due to mental impairment. There are obvious dangers for a woman in having her abusive partner act as nearest relative. Here are some suggestions that you can support the woman with:

- Help her to tell her mental health support staff about the violence she is experiencing at home so they can ensure they do not compromise her safety by dealing with the violent partner when she is experiencing mental distress/health problems.
- Help her to choose a trusted and safe member of the family to be her nearest relative so that a violent partner does not assume that role.

- Support the woman to ask staff to place a note on her file at the front stating that she should always be seen alone. This should be in all medical and health environments, not just mental health.
- See Representation Act Agreement section for further strategies that could be used.

There are more specific vulnerabilities and risks that can be associated with different kinds of mental health distress and some of these are mentioned below. We have suggested some actions you can consider undertaking with women to build safety and decrease risk. You may want to add to these from your own experience.

### 3.3.9 Post-Traumatic Stress Disorder

When someone is a trauma survivor they can suffer from hyper-arousal, which can impact on safety on a number of levels. Hyper-arousal can quickly drain a person's physical and emotional resources, interfere with sleep, impair concentration and affect mood. A person may become easily distracted or have difficulty remembering, especially when under stress. There are dangers of over-reacting or under-reacting to current situations. Helping a woman to reduce her levels of stress wherever possible or manage it more effectively may help to improve concentration and memory to help with safety planning activities. Safety planning needs to take into consideration what impact the trauma symptoms have on a woman's ability to assess and respond to risks and dangers and be creative in thinking about ways of strengthening her response.

### 3.3.10 Self-Harming Behaviour

Some of the hardest challenges emerge around the issue of self-harm. When a woman self harms, particularly when she uses severe methods that inflict considerable physical harm to herself, many of us want to take control and move to action, including making the woman stop self-injuring. Remember that many dangerous behaviours (cutting, substance use) represent desperate attempts by women to manage or avoid terrible pain. Safety is as much a subjective experience as an objective one. When we ask women to stop these behaviours we may be asking them to tolerate intolerable feelings, be swamped with terrible memories and experience intense physical and emotional pain. That does not feel like safety. We must therefore continue to work in partnership, managing our own emotions constructively, even in very challenging circumstances, in order to allow a woman as much control as possible.

Self-harm is dealt with in detail in the section The Importance of Safe Conversation: Identifying Risk and Resources, and Appendices 7 and 8 have useful assessment tools. As with suicide, risks due to self-harm need to be explored during a general safety assessment, or a specific self-harm assessment (see Appendices 7 and 8), undertaken in partnership with the woman. Adopting a harm reduction approach can be effective as a woman moves towards safer methods of self-harm. If a woman is severely self-harming it is likely that we will need to make referrals to specialist mental health services and be working with these other agencies. It is always best practice to discuss any referral processes with the client and invite her active collaboration.

**It is important to differentiate life-threatening behaviour from other behaviours that make us very uncomfortable but that are not life threatening.**

Sometimes, usually only in life threatening situations, you will need to act to protect the client from herself and intervene without her collaboration. These will be unusual situations and will need to be done with the clear support and guidance of management in your service and probably with other agencies. Even in these situations a respectful, sensitive, caring and non-judgmental approach is essential.

### 3.3.11 Suicide

Suicide is also dealt with in *The Importance of Safe Conversations: Identifying Risk and Resources*. If suicide is a threat then this needs to be explored as part of a safety assessment, or a specific suicidal assessment (see Suicide Critical Incident form in Appendix 9 and information on preventing a suicide attempt in Appendix 10)

### 3.3.12 Depression and Blankness

According to a study by Golding (1999 in Humphreys and Thiara 2003) the average prevalence rate for depression in women experiencing violence from an intimate partner was 47.6%. Given how common depression is in the women we will be working with, we need to expect some of these features below to be present, rather than seeing them as unusual ways of being. These are some of the behaviours that a woman may present if she is depressed:

- Slowed up in movement and speech and thought
- Hopeless about life in general
- Very low self-esteem
- Low motivation or no motivation
- Inertia and withdrawal
- No reasons to think life could be better
- Poor sleep
- Poor eating
- Things that used to give pleasure no longer do

#### Reflective Question

**H**ave you witnessed some of these behaviours affecting a woman's safety? If so, how?

### 3.3.13 Psychosis: Commentary And Approaches To Help Women

*"I need someone who could just be there— non-judgmental, solid, not trying to force me to do this or that, just being with me and helping me to make sense of some very frightening, but also very beautiful and visionary experiences."*

*"The problem is not so much the voices as the inability to cope with them."*

(From materials on [www.mind.org.uk](http://www.mind.org.uk)).

One of the most challenging areas of our work is how to support a woman's safety when she is in and out of reality. Some signs that a woman may be experiencing a psychotic state of mind may be:

- Withdrawal and loss of interest in the external world
- Loss of energy and motivation
- Problems with memory and concentration
- Deteriorating ability to manage work, study or family life
- Lack of attention to personal hygiene
- Confused speech or difficulty communicating
- Lack of emotional response or inappropriate emotions
- General suspiciousness
- Sleep or appetite disturbances
- Unusual behaviours

Any of these may also be due to experiencing violence in intimate relationships. Even some of the more unusual experiences such as hearing voices can be surprisingly common in the general population. A large number of people with no other mental health issues have heard voices in the normal course of life, particularly during periods of stress or loss, and many also hold beliefs that others would consider unusual.

Psychosis is usually only diagnosed if a person experiences distress along with their voices or experiences the voices telling them to do things that they wouldn't ordinarily do. Some people take voices in their stride and others feel overwhelmed by them. Some people experience their voices as benign and helpful: as guiding them in life. Others experience them as hostile and nasty where the voices are belittling and ridiculing them. The most distressing voices tend to be those that are punishing and controlling of a person, even instructing them to harm themselves and others. Not everyone's voices have this element but voices can change and become more hostile over time. Some delusional ideas can be extremely frightening too, especially if they involve paranoid ideas.

For someone experiencing voices or other forms of hallucinations, they are very real to them. Someone who is experiencing psychosis may be terrified of what is happening to her or she may have grandiose feelings about it, like "I'm going to save the world from evil." It is important to know how the woman herself perceives the voices.

Having someone who a woman can trust and talk to, who will not judge her, will be critical to aiding her stability and recovery. Empathy— as always— is key. A trusting collaborative relationship is the main ingredient of helping women with psychosis. Don't underestimate the power of this.

The following points may be helpful for you to keep in mind when working with women who are experiencing psychosis:

- Some schools of thought suggest that the most helpful thing for a person with psychosis is for someone else to accept their reality and assist them to cope and live with their beliefs. Avoid getting into situations of either confirming or denying a woman's specific experiences or beliefs— focus on a full acceptance of the experiences as real for the woman herself (see [www.intervoiceonline.org](http://www.intervoiceonline.org) for more information on this).
- Normalize and validate her experiences wherever possible. Acknowledge it when you can see truth in what a woman says. The following statements may be helpful:
  - Many people would feel very similar in your situation.
  - It is very common to have the experiences you are having. Some people find it helpful to on practical details of safety like getting food, shelter etc. Do you think this may help you?
  - It is common to feel very threatened and unsafe around others when you live in violent situations.
  - That must feel terrifying. How are you managing to cope?
  - I can see that you are trying to cope with so many demands on you. No wonder you are feeling so overwhelmed and upset.
- Find out what the voices, and other experiences like delusions, mean to her. What role are they playing in her life at this moment? What explanations can she give for their presence in her life? What are they about for her? Provide opportunities for women to talk and reflect on their experiences in a calm, supportive and non-judgmental atmosphere. Provide lots of emotional support.
- Acknowledging the resultant emotions is also critical, even if it is not possible to explore the meaning of the experiences. Is she angry, sad, resentful, defiant, scared? This can be done even when a woman

is actively in a psychotic space. It may become clear that there is a meaningful connection to explore between a woman's personal history, her current situation and the voices or delusional ideas.

- Help the woman to develop strategies to reduce her fear, and to increase her coping and ability to problem solve. Help her to develop strategies to improve her safe relationships and her quality of life. Stay focused on what, when, where, with whom. Where is she going to sleep tonight? Is there a friend she feels safe with? Are there shelter staff she feels safe with? If she feels she is being followed, who does she feel safe to be with right now? Let her know you never want her to be hurt.

**W**hen a woman is experiencing an alternate reality, the most important action a worker can undertake to support safety is to bring her back to NOW, if at all possible. Invite the woman to focus on practical details that will increase her chances of safety.

- Help the woman focus on her basic needs. Cycling through psychosis is tough and can often lead to time on the street, where one's safety is highly compromised. Ask about eating, shelter, clothing, access to medications etc.
- Many people who hear challenging voices have found that a turning point in learning to cope with the experience has been in finding different ways of talking with and understanding their voices. An approach based on this idea (see Corstens and May 2007) suggests that learning to understand the motives of the voices and trying different ways of talking with them can help the relationship to change between the voice hearer and the voices. This approach is based on techniques derived from various psychological traditions such as Transactional Analysis and Psychodrama. These are not approaches that mainstream psychiatry would adhere to but many consumers/survivors welcome the practical and validating nature of them.
- Support workers usually recommend plenty of sleep, exercise, a nutritious diet, a social support network, positive family connections, meaningful work and structured days.
- Regular appointments with a mental health worker can also be very helpful (provided they are able and willing to work with the interconnections between a woman's mental health and her life situation).
- Help her to make informed treatment decisions if she uses mental health services (see Broadening the Lens and Moving towards Empowerment).
- Discuss her medication: staying on medication over a long term can be challenging if there are serious side effects. Staying on medication during an episode of psychosis is particularly challenging and coming off medication abruptly brings on other complications. If a woman decides to stop taking medication, it is helpful to ask questions that assist her in connecting to the possible outcomes. What has happened in the past when you came off of medication? Did you stay safe? Did you end up in the hospital? Did you feel better? You may find that working with a harm reduction approach to staying on medication is helpful.
- Help her to regain confidence: many women feel ashamed by their psychosis, have low self-esteem and feel powerless.

- Early interventions are considered to be very important in terms of preventing a deterioration of mental wellbeing. With this in mind, help a woman to learn the early warning signs of an episode of crisis. Create a Ulysses Agreement (see section on the Representation Agreement Act, Ulysses Agreements and Advance Directives for more information) for action to take if a woman becomes unwell, with a group of safe others committed to supporting the woman.
- Help her to learn from her own body/mind/spirit what helps her to stay balanced and well. Help her to explore what her ideas of healthy choices are, and how she can put these into place for herself. Help her to think through what a balanced life is for her, in terms of her mental and emotional wellbeing.
- Explore together some relaxation tools that a woman is comfortable with and can easily put into practice on a regular basis— yoga, massage, aromatherapy or reflexology can be helpful for many women but this needs to be checked out, as some, especially ones involving physical touch, may feel too intense and overwhelming for some women who are in the midst of a psychotic episode.
- Local self-help groups can be very helpful to women who have these experiences— explore whether there are support or self-help groups in your local area for women with similar experiences. What other supportive or peer resources are there locally that may help her?
- Cognitive therapy helps to focus on the links between thoughts, feelings and actions and can help a person to put in practice strategies to cope with specific symptoms; consider making a referral for this type of therapy if the woman is interested and able to manage this level of insight-based work.
- Be hopeful and optimistic in your work with her.

### **3.3.14 Safety Planning With Women Who Are Highly Dissociative**

BY MAGGIE ZIEGLER

#### What Is Dissociation?

Dissociation is the capacity to compartmentalize different aspects of experience such as memory, feelings and thoughts. Survivors of abuse and violence often suffer from some degree of dissociation. Dissociation ranges from mild daydreaming or fantasizing about something to complicated divisions within the self. In mild dissociation there is awareness of wandering off and returning, but in more severe forms awareness is compromised or entirely lacking.

#### What Are Safety Considerations Specific To Dissociation?

1. All of the safety planning and safety increasing activities described in this tool kit are of great benefit to women with dissociative tendencies. In particular, the container activities (see above) assist women to make their internal process more conscious and the grounding activities (see Appendix 19) support women to pay attention to what is happening in the here and now. Consciousness and grounding enhance safety.
2. It is important to ascertain a woman's ability to hear and retain information. There is no point creating a safety plan she is not going to remember or doesn't understand.
  - Encourage women to take notes while discussing safety. Unless there is an issue of literacy or some other reason why she cannot write, writing is a physical act that enhances memory.
  - Don't let your own urgency about her situation lead you to cover too much information or make a safety plan too quickly. Leave time for integration.

- Identify her capacity to hear and integrate information through questions such as:
  - This is a lot of information. Can you tell me what stands out for you?
  - Would it be helpful for you to write this down?
  - Let's review this safety plan before you leave. Why don't you share with me your sense of what you've agreed to? Let's go over the notes you took.
  - Where will you keep these notes and what would help you remember where they are?

3. Practice building safety in the relationship between you and the woman. Dissociation often involves a lack of awareness of shifts in moods or states. A woman might be engaged in conversation and then seems to drift off, but she might not be conscious of doing so. If she is aware of the shift, she might not know why she suddenly spaced out of what she was feeling and experiencing at that moment. This has implications for safety in the relationship and also for safety planning. Helping her track shifts in attentiveness and awareness is important. It may be helpful to go over a handout that delineates the differences between dissociation and self awareness (see Appendix 13). In order to create safety in the conversation, pay attention when her attention wanders.

- Ask questions that encourage curiosity. These provide information about what is happening between you as well as how she dissociates. She might be feeling unsafe with you for some reason, or on information overload.
  - I noticed you were staring out the window. What was happening just then?
  - Was there anything I said or did that caused you to go somewhere else?
  - How do you feel about how our conversation has been going?
  - What would help you to stay present?
  - What do you need from me? What could I do differently?
  - Is this what you do in your life when things are difficult or dangerous?

4. Focus on increasing her ability to follow through on the safety plan.

- Ask questions that help increase her awareness of the gap between something being wrong and mentally accessing her safety plan. Conversation around the following questions leads to more usable plans.
  - Do you think you will remember this safety plan when you need it?
  - What would help you remember?
  - Have you had experiences in the past when you've managed unsafe situations successfully? How did you do that? What made it possible to do that? What would make it possible to do that again?
- Make sure to follow up on how successful the woman was at implementing her safety plan. Review together what happened and track how well she was able to access the safety plans and the blocks to doing so. This will lead to a revised plan.
- Be patient. The goal is for the woman to increase her ability to stay safe, both externally and within herself. If you view this as a process you will both be less frustrated. Appreciate small successes and take "failures" in safety as learning opportunities. The more dissociated a woman is, the more complex this process becomes. If you ignore the obstacles, blocks, or the aspects of self that may not be interested in safety, you won't get very far. Contracts are not always helpful as they can lead to shameful feelings about "not doing it right."

5. One of the most helpful skills in increasing safety is mindfulness in the present moment. It is often at the moment of danger that dissociation occurs. This is a learned defence but the woman lacks the ability to protect herself in a dissociated state because she is not attuned to the present moment. She becomes more vulnerable.

Staying in the present moment means observing alertly what is going on internally and externally without being trapped in what is happening. This reduces dissociation. The woman sees that a flashback is a flashback—she knows she is simply remembering the past and not reliving it. For example, the peculiar man on the street is not the man who raped her and she knows how to act to maximize her safety.

The following guidelines for mindfulness are adapted from Marsha Linehan's *Skills Training Manual for Treating Borderline Personality Disorder* (1993). Consider taking training in mindfulness in order to use this with women.

- Observe your experience by noticing everything carefully. Practice not reacting to situations, or the feelings or thoughts that you observe in yourself. Stay alert to all of your thoughts, feelings and experiences and notice them with all your senses.
- Describe your experience in words. Name feelings as feelings, thoughts as thoughts, behaviours as behaviours.
- Participate by allowing yourself to become involved with the present moment. This allows access to intuitive knowledge. Practice implementing your safety plan and skills that change harmful situations.
- Accept yourself and your situation as they are.

### **3.3.15 Wider Supports That Can Promote Women's Safety**

#### **Ulysses Agreements**

As described in another section of this tool kit (The Representation Agreement Act, Ulysses Agreements and Advance Directives), Ulysses Agreements or crisis plans are a way of putting plans in place before a crisis or a period of mental ill-health occurs, and these are one of the best ways of informing others (family, friends and professionals) of a woman's wishes if or when she becomes distressed or unwell. A woman can make it clear what triggers a breakdown in her mental wellbeing and signs of increased mental distress. She can describe what helps her in these situations and whom she would like to help her. This open communication and planning can help others to be in a position to help a woman if/when she becomes unable to manage her affairs. Plans for the safety and wellbeing of children can be made using these agreements too. Mental ill-health can be used by partners to attempt to get custody of children when a woman is hospitalized, so advance planning, and informing professionals of the risks to children from violent partners, can be important strategies to keep children safe.

#### **Interagency Coordination**

One of the best ways to more generally support women with mental health problems who experience violence is to build relationships with mental health services and professionals who have a sensitive and informed perspective on the interconnectedness of these issues. Having trusting and respectful relationships with key professionals in other agencies can help to break down the barriers between anti-violence and mental health agencies and this will benefit women who have intersecting concerns. This issue is dealt with more extensively in the section *Advocating for Women's Safety*.

#### **Address Community And Neighbourhood Safety**

Women with mental health problems are more at risk of being victimized in the community, so time should be spent exploring these risks, particularly if the woman puts herself in risky situations such as using substances or being engaged in street sex work. Personal and neighbourhood safety techniques can be thought through in advance in safety planning discussions. Helping a woman to recognize sexual harassment and discourage unwanted advances, providing sexual assault awareness and prevention and assertiveness training can all help to build her resources and her ability to keep herself safe.

## Conclusion

For many women who experience both violent relationships and mental health problems, the issues intersect in complex ways that prevent generalizations. Safety planning therefore needs to be a highly individualized process. It should be anticipated that discussions about risk, threats, dangers and planning for safety will take longer with someone with these intersecting issues (and even more so for women with additional substance use concerns). Safety planning will need to explicitly address internal (emotional) as well as external threats to safety. This discussion should help her to plan more effectively for times of crisis and be more realistic about the strategies she has available to her. Identifying what she is in control of, as well as what she is not in control of, is vital to help support her confidence and self-efficacy.

Peer and informal supports can be as helpful (sometimes more so) as professional supports. Continually supporting a woman in building her personal/peer support networks is critical in creating a wide network that she can draw on for all times of her life. Seek out those local professional supports that are sensitive to women with intersecting violence and mental health concerns and that aim to help them on their own terms. Review safety plans regularly with women. Check whether she feels her plan is still helpful and relevant, particularly after a crisis has taken place. Aim to strengthen her overall her confidence that she can indeed take steps to help herself and her dependents. Help her to see that each small step she takes can help to move her towards safety and wellbeing, however painstaking the process may be.

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The International Community for Hearing Voices

[www.intervoiceonline.org](http://www.intervoiceonline.org)

This is the website for *The International Community for Hearing Voices* which is an excellent resource on the experience of hearing voices. It includes many different perspectives on the voice hearing experience and a good number of helpful resources, publications, research projects, training opportunities and events. Some of the readings here will be very helpful for working with women who are in different states of reality or having unusual experiences commonly associated with psychosis.

# 3.4 Safety Planning with Women Using Substances

BY TESSA PARKES

## 3.4.1 Substance Use And Safety: Making More Connections

*“Substance use and intimate partner violence are not linked in a linear manner, but interconnect in a web of social and structural issues” (Greaves et al 2006).*

For many women experiencing violence, patterns of substance use are closely linked to the violence and abuse that they are experiencing. This link should not be understood as a causal relationship, “but [as] one where the practice issues of safety planning, and identifying the strategies of power and control, need to be addressed in the context of, and intersection with, problematic substance use” (The Stella Project 2005). In addition to this, and as described earlier in this tool kit, research has shown that as many as two-thirds of women with substance use problems may have a concurrent mental health problem such as depression, post-traumatic stress disorder, panic disorder or an eating disorder (Poole 2004). This means that many of the women you work with will be trying to cope and manage all three problems: violence, mental health problems and substance use. While the sections on safety planning for a woman with mental health problems and substance use problems have been written separately, there is obviously much overlap in the issues and in how they present for women in their lives. We hope you will start your safety planning process with a focus on violence, and then add on mental health and substance use issues when appropriate to do so.

*“It is important for anti-violence services to work from the assumption that the women they serve will likely need to examine their current substance use in the safe context that an anti-violence service can provide. And the work that anti-violence services do with women on safety planning and identifying the workings of power and control needs to be informed by the realities of problem substance use” (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4 2007).*

To undertake effective safety planning with women who use substances, we need to understand the context of their lives and the interconnectedness of violence and substance use. There are many interconnections, for example:

- Many substance-using women who are in violent relationships were introduced to drugs by their partners, who then use substances to gain and maintain power and control.
- Many women with substance use problems began by using substances that were prescribed by their physicians.
- Alcohol and drug use, by the perpetrator or the women herself, is associated with greater severity of injuries and increased lethality rates.

- For IV drug users there may be risks associated with their partner using the drug use to abuse them, by, for example:
  - forcibly establishing drug use in the context of a relationship
  - forcing women to trade sex for drugs
  - determining the woman's drug supply
  - shooting up for the woman
  - deliberately using dirty needles or cottons or missing a vein on purpose (Bland 2001)
- A woman may be dependent on her abuser for access to drugs and this may be a factor preventing her from leaving.
- The compulsion to drink or use may make it difficult to access services such as shelters, advocacy or other forms of help.
- Service providers may see women as having reduced credibility if they have substance use problems, which can reduce their access to community supports.
- The wider impact of a chaotic lifestyle may also create problems, with a woman having little control over who is around her and her environment in general.
- Women in violent relationships who have substance use problems often believe that their use of a substance means the violence against them is warranted.
- Active and regular substance use can make it harder to escape from a violent situation or to heal from past abuse.
- For a woman experiencing violence, substance use treatment may be seen as less urgent than getting safe.
- Women who use substances may be more reluctant to seek assistance or contact police for fear of arrest, deportation or child protection service involvement.
- A woman may fear that she will not be believed if she makes a complaint—this may have been borne out for her in prior experiences.
- If she is in recovery from using substances, she may fear relapse if she leaves to face an unknown future (Alaska Network on Domestic Violence and Sexual Assault 2005).

We have included a Power and Control Wheel for Women's Substance use (O'Neil 1996, adapted from the Domestic Violence Intervention Project, Duluth) in Appendix 21. This provides more detail on how substance use can be dynamic in violent relationships.

### 3.4.2 Risks To Safety

Because of this interrelatedness of violence and substance use, cessation of drinking and drug use alone cannot ensure safety. Indeed, recovery is often accompanied by more danger for women, as the violent partner finds that they are less able to control them than previously. They may seek to gain new ways of control and to sabotage recovery or treatment efforts. The exact risks will obviously vary for different women; for example, in rural contexts further isolation and disconnection from social and community supports may be particularly destructive, in addition to the lack of anonymity.

When under the influence of substances, a woman may be less able to accurately assess the level of danger posed by a perpetrator, and she may have impaired judgment and thought processes in a number of areas that make safety planning more difficult:

- She may think she has more power than she does and can defend herself against her partner during a physical assault.
- She may find it more difficult to make decisions that might protect her from the abuser.
- She may have a harder time recognizing options or gauging her safety if a situation escalates.

- She may have no memory or a distorted memory of violence that happened when she was under the influence; she may think she is able to handle it.
- She may fail to remember how an injury was sustained or fail to remember making a police report.
- She may find it more difficult to remember a safety plan.

Despite many of these difficulties we need to still see the woman survivor as the expert on her own and the abuser's behaviour and likely responses. We can combine her expertise with our professional wisdom and research evidence.

### 3.4.3 Conversations Aimed At Reducing Risk And Increasing Safety

**"Critical to supporting women with substance use problems is reducing shame about having a problem, promoting understanding of substance use and its risks, as well as eliciting hope that change is possible" (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 3 2007).**

Given the shame, guilt and other negative emotions connected with substance use for women it is vital that our conversations with them acknowledge these negative emotions and show our respect for them as women and for their struggles:

One of the most important interventions you can make is to have a conversation with a woman where her substance use is discussed, she is asked about how her use affects her and what she needs to stay as safe as possible. Crucially, we also need to ask how her or her partner's substance use is affecting the violence she is experiencing. A woman may find it easier to talk about her partner's use before she feels safe enough to talk about her own.

Questions to ask a woman who is using substances to help with safety planning include:

- Does your partner use your drinking or drug use to hurt you? If so, how?
- Has your partner used alcohol or drugs to control/threaten/shame you? If so, how?
- When you were not drinking or using drugs in the past, what helped you to cope? Can you do that now?
- Can you tell me why it may not be safe to use when someone is being violent towards you/stalking you?
- How can your drinking or drug use (together with your experience of violence/trauma) affect your parenting/housing/police response/legal response/interactions with MCFD, other systems or issues?

**R**ecognizing that violence towards women can be connected to an increase in use or be a relapse issue (can make women turn back to using substances after having worked on quitting) is crucial ([www.accessingsafety.org](http://www.accessingsafety.org)).

### 3.4.4 Strategies To Use To Increase Safety: The Value Of Harm Reduction

A harm reduction approach can be very helpful when discussing women's safety when she uses drugs or alcohol. A conversation focused on altering use provides more room to work together and provide support than a conversation promoting abstinence. For example, she could consider switching to safer drugs, reducing the number of drugs used, eating before drinking, etc.

Another approach would be to ask her questions about the context of her use and how this context creates additional vulnerability. Questions such as

- Where do you commonly use/drink?
- Who is around when you are using?
- What dangers do these people present to you?

Exploring together how a woman may keep herself safer in potentially unsafe contexts and around unsafe others may also be very helpful for her. You can help her to explore what choices she may have in exerting control in potentially risky situations. Questions that may be helpful here include:

- Are you able to use/drink with safer people?
- Are you able to drink/use in less risky places?
- What can you do when others'/partner's threatening or risky behaviour starts to escalate?
- Is there someone you trust whom you can call to come and help you if things start to escalate?

Some other areas you may want to consider are:

- Providing information—Provide information (in different formats) to women who use substances on their increased risks and ask for their collaboration in discussing ways of minimizing the risks associated with their substance use (see section on harm reduction approach for more ideas here).
- Risks from treatment—Substance use treatment can be risky for women in a number of ways:
  - They may encounter re-traumatizing practices as part of their treatment, such as feeling coerced into particular ways of stopping or reducing their use.
  - They may encounter approaches that add to their shame and guilt rather than offering them acceptance and hope.
  - They may not be able to access women-only services in their local area, which may make them vulnerable to being in physically unsafe or emotionally unsafe environments.
  - They may have to make a choice between staying with their children and getting treatment. This may be risky in a number of ways, particularly if the woman fears for her children's safety or fears that she will lose custody if she places herself into treatment.
  - sWhere possible, try to help a woman to access treatment settings that are sensitive to the needs of women in violent relationships. This is not always possible, particularly in rural and isolated areas. If not possible, try to maintain contact with a woman while she is in treatment to continue your support.

Sometimes new risks are presented when women access substance use treatment. For example, women who access methadone programs may be tracked by abusers because of the need to appear daily at a set time for their prescription. This and other individual risks need to be considered when drawing up a safety plan.

- Attend to the substance use directly— If a woman has indicated that she wants to stop her substance use, then you could create a substance use recovery plan to work alongside the safety plan. This acknowledges that the two issues are profoundly related. If she does not want to make abstinence-

focused changes, then a substance use harm reduction plan can be discussed along with her safety plan (see *Moving Towards Safety: Using a Harm Reduction Framework*). Ideally, a referral to a woman-centred substance use/addiction service would occur when a woman is ready to quit or substantially alter her use. With her consent, it would be important to share her safety plan with her addiction worker, so that the recovery plan they create complements and supports her safety plan. Checking in with her on her recovery efforts and evaluating any impacts on her safety remains part of the anti-violence work.

- Referrals and support from other agencies—Where at all possible, try to partner with appropriate woman-centered substance use services to facilitate referrals and coordination.

### Good Practice Example

**"A**t the Jean Tweed Centre, a women's addictions treatment centre in Toronto, counsellors have identified the parallels between supporting women in developing violence/trauma safety plans and relapse or risk reduction plans regarding substance use. Helping women make the connections between their safety planning, growth and change in both areas can be facilitated by both violence and substance use counsellors" (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4, 2007).

- Peer and mutual support— Find out if there are any integrated support groups (for substance use and violence against women) in your area, and if not, think of helping women start one. It can also be helpful to have copies of "A woman's way through the 12 Steps" by Stephanie Covington available in your services to help women get what they want from traditional support groups. (Dr Covington's website is <http://www.stephaniecovington.com/> and to order the book go to <http://www.amazon.ca/exec/obidos/ASIN/0894869930>.)

### Alternative Support Groups

**T**here are alternatives to the 12-step groups that provide options for those who do not feel comfortable with this approach. They are not as commonly available as 12-step groups but they tend to also have websites and online meetings as well as meetings in larger cities. The 16 Steps of Discovery and Empowerment group, developed by Charlotte Kasl, interprets the 12 steps in alternative ways that are more suited to women and other marginalized groups of people. The groups are based on approaches in her books *Yes You Can!* and *Many Roads: One Journey: Moving Beyond the 12 Steps*. Her version of the steps encourages those that attend to examine beliefs, addictions and dependent behaviour in the context of living in a hierarchical and patriarchal culture. See [www.charlottekasl.com](http://www.charlottekasl.com) and use the email address at the website for information on online support groups.

## Good Practice Example

Victoria Women's Sexual Assault Centre (VWSAC) identified the need to provide more in-depth support for women experiencing Post Traumatic Stress Disorder and substance use problems. They observed that women with trauma-related, mental health and substance use problems are often in crisis and rotate through services trying to get their needs met. VWSAC fostered a community collaboration that provides an integrated treatment model utilizing the *Seeking Safety* group model (Najavits 2002) as its foundation.

The programming consists of two connected yet stand-alone groups:

- *Seeking Information* (three or four weeks) explores the links between trauma and substance use. This group provides women with basic information and skills before making the commitment to a 12-week group;
- *Seeking Understanding* (11 or 12 weeks) examines specific topics related to trauma and substance use in more depth.

The groups are co-facilitated by a trauma counsellor and a drug and alcohol counsellor. Group goals include:

- Building awareness of the effects of trauma and substance use, the connection between the effects of trauma and substance use, and new ways of coping without substance use;
- Learning about new skills and having an opportunity to practice. Skills include things like problem solving, safety planning, asking for help, taking care of yourself, and harm reduction or abstinence;
- Increasing positive beliefs: decreasing shame and isolation and increasing self-esteem, self-acceptance, personal power, trust in self and others, self-awareness, hope (change is possible), compassion for self, and internal and external resources. (Poole and Coalescing on Women and Substance Use Virtual Community, Information Sheet 4, 2007)

Their materials on working with women to assess potential risks, dangers, triggers and potential relapse situations, and to build internal safety, are excellent resources. Resources are given to women that help to develop self-caring and self-soothing skills and routines and containment strategies and to build the ability to tolerate painful feelings (see Appendices 14–20 for the resources we have been given kind permission to reproduce in this toolkit). Two additional resources from the VWSAC are *What inspires my healing?* (Appendix 22) and *How substance use prevents healing from PTSD* (Appendix 23). These are excellent resources to consider sharing with women.

Substance use may reduce a woman's  
ability to gauge her level of risk

### 3.4.5 Additions To Safety Plans

**W**hen we are helping a woman with her substance use we need to remember that she may not have the autonomy or safety to be able to reduce her use without negative repercussions from an abusive partner.

In the context of drug or alcohol use, a woman may need to make specific safety plans or have additional aspects to her plan. Violence against women, drug overdoses and withdrawal from substances can all be lethal, so it is vitally important that the risk from each is assessed as well as the risk of a woman harming herself deliberately. These assessments should be reviewed regularly because of possible frequent changes in a woman's situation and emotional wellbeing. The Alaska Network on Domestic Violence and Sexual Assault has a resource kit called *Getting Safe and Sober: Real Tools You Can Use* on their website [www.accessingsafety.org](http://www.accessingsafety.org). The following suggested additions to a woman's safety plan have been taken and adapted from their tool kit and other online resources. This is an abstinence oriented safety plan and will not be appropriate for all women.

#### *Mini Safety/Sobriety Plan at a Glance*

- **Strategize** – Steps to reduce risk/use
- **Develop** – Options to keep safe/sober
- **Identify** – Trusted allies/safe sponsors
- **Plan** – Means to escape abuser/drugs
- **Discuss** – Referral resources
- **Avoid** – Danger/persons/places/things
- **Tools** – HALT/one day at a time.

This last point encourages a woman to recognize vulnerability cues such as HALT (be aware when you are hungry, angry, lonely or tired) and take one day at a time in moving towards safety and recovery. Understanding and planning for the physical/emotional/cognitive/environmental triggers and other cues indicative of risk is very important (see Appendices 13-17).

The following script could be added into and amended for use in a woman's safety plan where appropriate:

If drug or alcohol use occurs alongside violence in my relationship with my partner, I can enhance my safety by some or all of the following:

I will try to remember that:

- It is easier to keep safe when I am not using substances<sup>1</sup>
- Alcohol and drug use can impair my judgment and make it harder for me to choose safe options and access services
- I find it hard to ask for help when I am using or drinking.

<sup>1</sup> This is generally the case, but some women may be safer when they are using with their abusive partner.

Things I can do:

- I can call \_\_\_\_\_ for support when I feel like drinking or using to cope.
- The following people/places/things can be unsafe for me  
\_\_\_\_\_
- My warning signs that I am getting stressed and craving substances are  
\_\_\_\_\_
- and this is what I will do in these situations to try to keep myself from drinking/using and to try to keep myself safe  
\_\_\_\_\_
- If I am going to use, I can do so in a safe place and with people who understand the risks of violence and are committed to my safety. I can  
\_\_\_\_\_
- I can also  
\_\_\_\_\_
- If my partner is using/drinking I can  
\_\_\_\_\_
- I might also  
\_\_\_\_\_
- To safeguard my children I might  
\_\_\_\_\_
- Other things I can do to help me feel stronger are  
\_\_\_\_\_

(Alaska Network on Domestic Violence and Sexual Assault 2005)

This script has also been placed in Appendix 24 as a handout.

### 3.4.6 Knowing When To Act Quickly: Managing Withdrawal And Overdoses

It is important to be aware of indicators of withdrawal or overdose in case you need to act quickly to get medical help. Drug emergencies are not always easy to identify. If you suspect a woman has overdosed, or if you suspect she is experiencing withdrawal, give first aid and seek medical assistance.

#### Effects of Different Drugs

- An overdose of narcotics can cause sleepiness and even unconsciousness.
- Uppers (stimulants) produce excitement, increased rate of heartbeat, and rapid breathing. Downers (depressants) do just the opposite.
- Mind-altering drugs (hallucinogens), including LSD and other street drugs, may produce paranoia, hallucinations, aggressive behaviour or extreme social withdrawal.
- Cannabis-containing drugs, such as marijuana, may produce euphoria, relaxation, impaired motor skills, and increased appetite.
- Legal prescription drugs are sometimes taken in overdose to achieve effects other than the therapeutic effects for which they were intended. This may lead to exaggeration of their effect (as can happen with uppers and downers), or serious side effects. (Adapted from [www.helpguide.org](http://www.helpguide.org).)

*Drug overdose symptoms* vary widely depending on the specific drug(s) used, but may include:

- Abnormal pupil size
  - Dilated pupils (enlarged)
  - Pinpoint pupils (very small)
  - Nonreactive pupils (pupils do not change size when exposed to light)
- Sweating
- Agitation
- Tremors
- Convulsions
- Staggering or unsteady gait (ataxia)
- Difficulty breathing
  - Shallow, decreased breathing (respiratory depression)
  - Labored breathing
  - Rapid breathing (tachypnea)
- Drowsiness
- Unconsciousness (coma)
- Hallucinations
- Delusional or paranoid behavior
- Violent or aggressive behavior
- Death

*Drug withdrawal symptoms* also vary widely depending on the specific drug(s) used, but may include:

- Abdominal cramping
- Agitation
- Cold sweat
- Convulsions
- Delusions
- Depression
- Diarrhea
- Hallucinations
- Nausea and vomiting
- Restlessness
- Shaking
- Death

### **Withdrawal from Benzodiazepines**

Withdrawal symptoms can include insomnia, panic attacks, agitation, hallucinations, paranoia, depersonalization, derealization, depression, pressure in head, rebound anxiety, loss of appetite, weight loss, visual distortions, flashbacks, lack of concentration, agoraphobia, dizziness, sweating, nausea, nightmares, palpitations, creeping sensation in the skin, increased sensitivity to light, touch and smell, pins and needles, numbness and seizures and sometimes death (taken from [www.benzo.org.uk](http://www.benzo.org.uk)).

### **Depressant Overdose Symptoms**

- Moderate: uncontrollable nodding, inability to focus eyes, excessive drooling, pale skin colour, incoherent speech
- Serious: awake but unable to talk, body very limp, erratic or very shallow or slow breathing, excessive vomiting
- Severe: unconscious, blue skin, not breathing, can't find a pulse or pulse shallow and erratic, choking or gurgling sounds, lying in their vomit.

## Stimulant Overdose Symptoms

- Moderate: incoherent speech, extreme paranoia, pale skin colour, jaw or teeth clenching, aggressiveness, minor shakes, excessive sweating, clammy skin, very rapid pulse
- Serious: inability to focus eyes, vomiting, foaming at the mouth, pressure or tightness of the chest, unable to talk, erratic pulse and violent actions
- Severe: seizures, unconsciousness, choking or gurgling sounds, not breathing, no pulse From [www.heretohelp.bc.ca/publications/factsheets/crises\\_emergencies.shtml](http://www.heretohelp.bc.ca/publications/factsheets/crises_emergencies.shtml)

## Alcohol Withdrawal Symptoms

Withdrawal symptoms often develop in three stages:

1. The initial phase, which begins within a few hours after drinking stops, includes tremulousness ("the shakes"), irritability, nausea and vomiting, and difficulty sleeping. These symptoms reach peak intensity within 24 to 48 hours, and subside in two or three days. Alcoholic hallucinosis— very real "bad dreams" or actually seeing or hearing things that are not there— can occur during this phase.
2. In the second phase, convulsions (seizures, "rum fits") can develop within 24 to 48 hours after stopping even heavier drinking. Convulsions have been reported to occur as long as five and up to 20 days later. Except in persons with epilepsy, the standard treatment of moderate to severe withdrawal described below is usually adequate.
3. Delirium tremens (DTs) is the third and most serious stage of alcohol withdrawal. They occur four or five days after prolonged, heavy drinking stops, at which time the person becomes severely agitated, extremely confused and disoriented, and has dilated pupils, fever, and a very rapid heart rate. Frightening hallucinations and bizarre delusions can also occur.

Reassurance and supportive nursing care in subdued surroundings are the basis for treating alcohol withdrawal states. Chlordiazepoxide (Librium), diazepam (Valium), and other benzodiazepines are the drugs most commonly used. Particularly with DTs, electrolyte imbalances should be corrected and adequate fluids administered; hallucinations should be treated cautiously. Thiamine (vitamin B1) is usually given orally or intramuscularly to most patients treated for significant alcohol withdrawal (taken from information at [www.aadac.org](http://www.aadac.org)).

Try to make sure that women are well informed about these indicators— share this information with them if appropriate.

## Conclusion

**■ ■ Safety includes knowing you are not being labelled or judged" (Alaska Network on Domestic Violence and Sexual Assault 2005).**

As with the support of women with intersecting violence and mental health concerns, the issues for women with intersecting violence and substance use concerns are complex. Safety planning will need to take this into account and generate individualized plans that attend to the specifics of a woman's particular situation and that respond to changes in these situations. Allow plenty of time and patience for this process. Draw on harm reduction ideas to support your work with women, because this allows for much more creativity than simply taking an abstinence approach. Because these processes require honesty and trust to be effective, women require positive and non-judgmental supporters to help them with this challenging work. Ensure you can provide a woman with this in your working relationship and be prepared to meet her wherever she is at.

### 3.4.7 References, Resources And Further Reading

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