

# Mental Health Response



FOR DOMESTIC VIOLENCE ADVOCATES

# This Course Made Possible by

2

The Seattle Human Services Department, Domestic Violence and Sexual Assault Prevention Division.

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*The opinions, findings, conclusions, and recommendations expressed in this course are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.*

# Created by the DV/MH Collaboration Project

3

The development of this course was a collaborative effort by the following:

- **City of Seattle** Human Service Department, Domestic Violence and Sexual Assault Prevention Division
- **Consejo Counseling and Referral Service** – a social service organization that primarily serves Latino/as and has domestic violence and mental health programs
- **King County Coalition Against Domestic Violence** – a county-wide membership organization
- **New Beginnings** – a domestic violence organization
- **Seattle Counseling Service** – a mental health and addictions organization that primarily serves people who are LGBTQ
- **Sound Mental Health** – a community mental health organization

# Project Focus

4

The organizations are partners in the **Domestic Violence and Mental Health Collaboration Project**, a grant-funded effort to improve services for survivors of domestic violence with mental health concerns.

Since Seattle Counseling Service and Consejo specialize in serving LGBTQ and Spanish-speaking immigrant and refugee communities respectively, these communities are also a focus of the project.

# Enhancing Knowledge

5

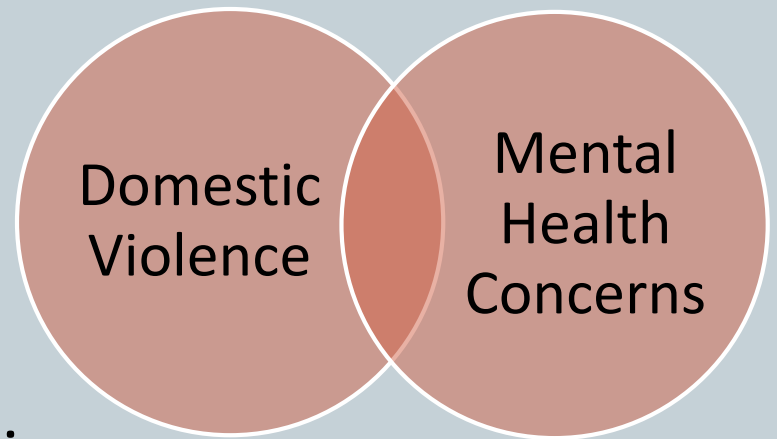
This course is a component of the Enhancing Knowledge Initiative of the project.

While the domestic violence advocates at the partner organizations participate in this course, the mental health providers at the partner organizations will participate in a course on domestic violence response.

# How will taking this course lead to change?

6

The purpose of this course is to increase your ability to respond appropriately to mental health concerns in a domestic violence advocacy setting.



This is one step in a process of systems change that the partners are undergoing in order to work together more effectively and to improve services.

# Other Project Steps

7

The other steps include:

- Creating more welcoming environments
- Enhancing knowledge of the intersection of DV and MH
- Making more effective referrals
- Utilizing liaisons
- Conducting cross-disciplinary case reviews
- Building stronger relationships between the partner organizations
- Increasing collaboration

# Expectations for this Course

8

- This course is intended to cover mental health response only.
- The content has been tailored specifically for domestic violence advocates.
- Information on mental health basics is provided in the course entitled “Mental Health Basics for Domestic Violence Advocates”
- If you are interested in learning more, please see the “Learn More” section at the end of this course.



# Course Contents

This course has 7 lessons:

1. Utilizing the Flowchart
2. Talking about Mental Health
3. Understanding Deliberate Self-Harm
4. Suicide Prevention
5. Accessing Mental Health Services
6. Collaboration and Consultation
7. Utilizing Liaisons

# Learning Objectives

10

**AS A RESULT OF THIS COURSE, YOU WILL BE BETTER ABLE TO:**

- 1. Utilize the project flowchart to make decisions about how to best assist a survivor of domestic violence with mental health concerns**
- 2. Communicate effectively with survivors who have mental health concerns**
- 3. Differentiate deliberate self-harm from suicide attempts**
- 4. Explain why survivors of domestic violence might deliberately harm themselves**

# Learning Objectives continued

11

**AS A RESULT OF THIS COURSE, YOU WILL BE BETTER ABLE TO:**

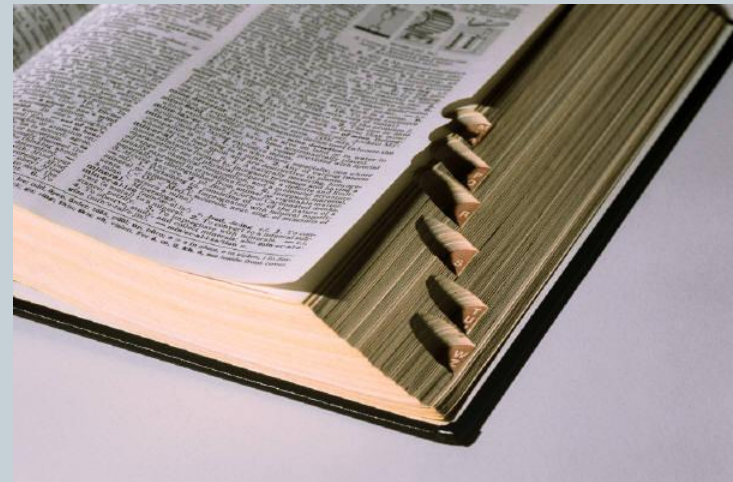
- 5. Explain why survivors of domestic violence might feel suicidal**
- 6. Talk to a survivor about suicidal thoughts and feelings**
- 7. Make an appropriate referral for mental health services**
- 8. Collaborate with mental health service providers**
- 9. Obtain consultation from mental health service providers**
- 10. Utilize your organization's DV/MH Collaboration Project liaison**

# A Note about Language

12

Accompanying this course is a glossary that was created by the DV/MH Collaboration Project.

If you are not familiar with a word or term used in the course, please check the glossary for more information.



# Lesson 1: Utilizing the Flowchart

13

**AS A RESULT OF THIS LESSON, YOU WILL BE BETTER ABLE TO:**

**Utilize the project flowchart to make decisions about how to best assist a survivor of domestic violence with mental health concerns**

# Flowchart

14

The next slide depicts the flowchart for responding to mental health needs or concerns. This chart should be used together with any policies your agency has on mental health response.

Each step of the flowchart will be explained in subsequent slides.

There is a print version of the flowchart for your future reference.

# CONVERSATION OR OBSERVATION ABOUT MENTAL HEALTH

Concerning Behavior and/or Suicidal

Request for or Need for MH Services

No Observed or Disclosed MH Concerns

Imminent Risk

Moderate Risk to Self or Others

No Clear Risk to Self or Others

AND

Refer to Internal MH therapist

Share Resources Available

Call 911

Call Crisis Clinic 1-866-4CRISIS

Seek Consultation

Refer to Partner Orgs if needed

Internal Therapist

Supervisor

Liaison

Offer ROI

Connect with Therapist

Therapist & Client

Therapist, Client & Advocate

Therapist & Advocate

# Conversations about Mental Health

16

## Conversation or Observation about Mental Health

Conversations about survivors' mental health should take place **after** they have been accepted into services.

Asking survivors about their mental health prior to telling them they have been accepted into services can be a violation of the Americans with Disabilities Act (ADA).

Asking about mental health prior to acceptance into services may also lead survivors to think they need to hide that information in order to access services.



# Follow Their Lead

17

- However, if the survivor chooses to *initiate* a conversation about mental health or suicide prior to being accepted into services, then you should follow their lead and have the discussion. Be mindful to only ask follow up questions that will assist you in supporting them or making a helpful referral. You most likely do **not** need to know if they have a diagnosis or if they are taking psychiatric medication.
- If a survivor discloses wanting to die or thinking about death, follow the recommendations for suicide prevention covered in this lesson and in lesson 4.

# Conversations about Mental Health continued

18

After a survivor becomes a program participant and you have established some trust and rapport with the survivor, you are much more likely to be able to have a helpful conversation about their mental health.



Lesson 2 will cover how to have that conversation.

# Responding to MH Needs

19



Following your conversation with survivors about their mental health or following your observations of them, consider your next step. Is their behavior concerning? Is the survivor suicidal? Did the survivor ask for or appear to need mental health services?

Based on the answers to these questions, you will decide where to go next on the flow chart.

# Responding to MH Needs continued

20

We will cover what to do if:

- Your conversation/observations lead you to feel the survivor is acting in ways that are concerning or that the survivor is suicidal
- The survivor requests MH services or appears to need them
- You do not observe any MH concerns and the survivor does not disclose any concerns

We will start with concerning behavior and/or suicidality.

# What is the Risk Level?

21

**Conversation or Observation about Mental Health**

Concerning Behavior and/or Suicidal

Imminent Risk

Moderate Risk to  
Self or Others

No Clear Risk to  
Self or Others

If the survivor is exhibiting concerning behavior and/or is suicidal, then you need to consider the survivor's risk level for harm to self or others. Lesson 4 will cover how to determine risk level.

# Responding to Imminent Risk

22

Imminent Risk

Call 911



If the survivor is at imminent risk of killing themselves (at risk of suicide in the next day or two), then the recommendation is to call 911.

If you are able to explain the survivor's plan, their means to carry through the plan, and the immediacy of their plans, you will be more likely to get a helpful response from 911.

# Responding to Moderate Risk

23

Moderate Risk to Self or Others

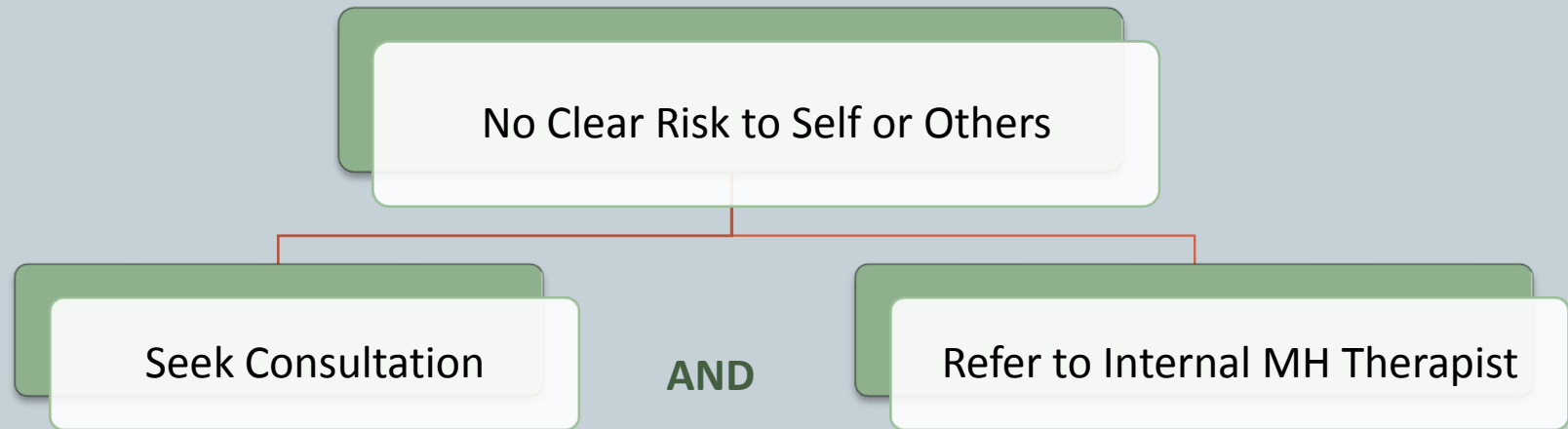
Call Crisis Clinic 1-866-4CRISIS

If the risk is not imminent, but the survivor appears to be at moderate risk for suicide or for harming others, then the recommendation is to call the Crisis Clinic for assistance. Ask for a supervisor, identify yourself as a DV advocate, and request consultation.

You could do this while the survivor is still in the room depending on the circumstances. Use your judgment about this.

# Responding to No Clear Risk

24

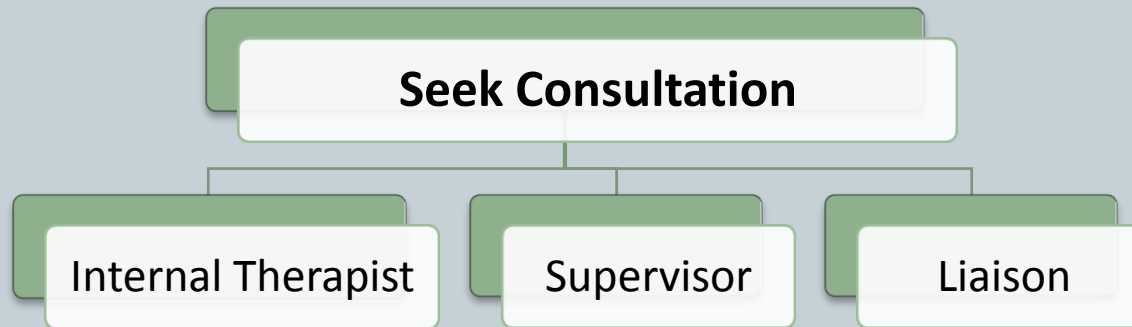


If the survivor does not appear to be a risk to self or to others, but is exhibiting concerning behaviors or is passively suicidal (i.e., thinking about dying, but not taking steps to make it happen), then seek consultation *and* refer the survivor to a therapist at your organization.



# Consultation

25



Obtain consultation regarding a survivor's concerning behavior or thoughts about suicide from a therapist at your organization or from your supervisor. If you need another option, your organization's liaison can help you obtain consultation from someone else at your organization or at one of our partner organizations. This should be done in a timely manner.

Lesson 6 will cover consultation and lesson 7 will cover how to utilize your liaison.

# Internal and/or External Referrals

26

## Conversation or Observation about Mental Health

Request for or need for MH Services

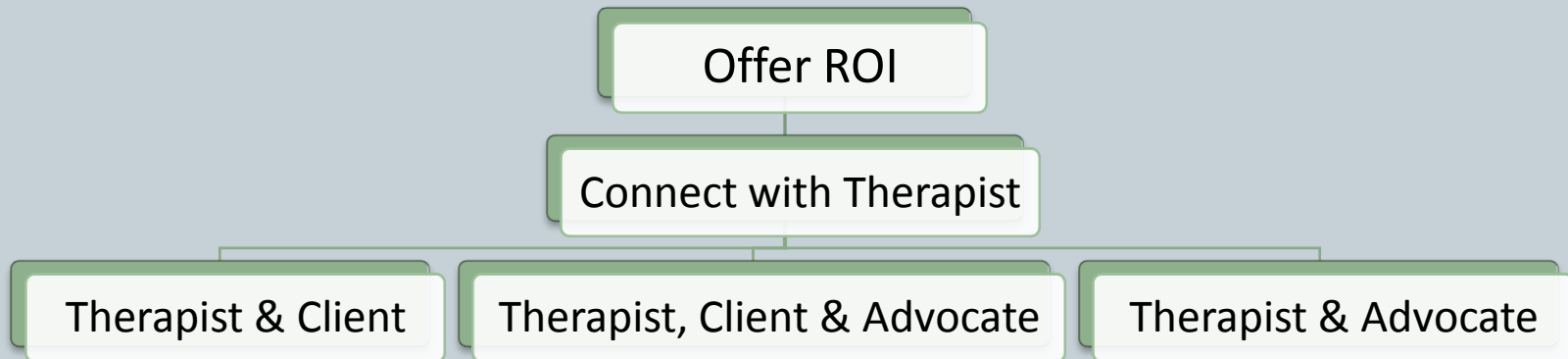
Refer to internal MH therapist

Refer to partner orgs if needed

If the survivor requests MH services or if you think the survivor would benefit from MH services, then refer the survivor to a MH therapist in your own organization, if that is possible. If services are not available at your organization or if the survivor is a better fit with another organization, then offer a referral to one of the partner agencies (Consejo, Seattle Counseling Service or Sound Mental Health.) Lesson 5 will cover how to access MH services.

# Collaborating

27



In the process of connecting the survivor with a therapist or after the survivor is connected, it is a good idea to talk to the survivor about the benefits of communication between you and the therapist or the 3 of you together. The choice is up to the survivor, but if the survivor would like this, then you can offer a release of information form (ROI) to sign and discuss the scope and nature of the communication. Would the survivor like the 3 of you to meet in person together or would a conference call be better? Does the survivor want you to communicate about particular issues and coordinate services or to not share certain information?

# No Mental Health Concerns

28

**No Observed or Disclosed MH Concerns**

Share Resources Available

If you do not observe any mental health concerns and the survivor does not disclose any, you still need to offer a referral for mental health services. It is important that you offer everyone the same referrals regardless of their behavior, so you do not appear to be favoring or discriminating against anyone. The referral may be helpful to survivors who are currently doing well, but may need some support in the future.

# The Flowchart

29

Now that we have discussed all of the steps on the flowchart, take a moment to review the chart as whole again on the next slide.



# CONVERSATION OR OBSERVATION ABOUT MENTAL HEALTH

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Therapist & Advocate

# Lesson 2: Talking with Survivors Who Have Mental Health Concerns

31

**AS A RESULT OF THIS LESSON, YOU WILL BE BETTER ABLE TO:**

**Communicate effectively with survivors who have mental health concerns**

# Labels

32

Labels can be great.

They can help us figure out what is in a box or a can on the shelf of a grocery store. (*Oh, it's peas.*)

They can help us find common ground. (*You're an Aries? Me too!*)





# Labels continued

33

They can help us get our point across with fewer words. For example, it is faster to say “survivor” or “consumer” than it is to say “a person who has experienced domestic violence” or “a person who receives mental health care” or even “a person who has experienced domestic violence and has mental health concerns.”

However, labels can sometimes be hurtful or demeaning. We all have many attributes and most of us do not want to be solely identified by just *one* of them.

# What Should We Call Sonia?

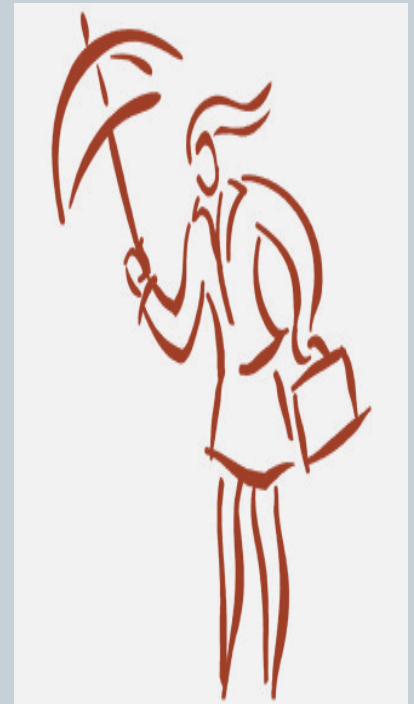
34

On Mondays Sonia participates in a domestic violence support group. At the group the other women refer to her as a “**survivor.**” The facilitator refers to her as “**program participant.**”

On Tuesdays Sonia goes to individual therapy. Her therapist thinks of her as a “**client.**”

On Wednesdays Sonia attends an LGBTQ AA meeting. The others there know her as an “**alcoholic**” and as a “**Lesbian.**”

On Thursdays Sonia has group therapy. There she is known as a “**consumer.**”



# What Should We Call Sonia? continued

35

On Fridays Sonia gets medical care. Her doctor sees her as a “**patient**” and also as “**disabled.**”

On Saturdays Sonia spends time with her family. Her family sees her as a “**sister,**” “**niece,**” “**aunt,**” and “**cousin.**”

On Sundays Sonia prays in Spanish at a predominantly Latino congregation. The priest calls her a “**congregant.**”

*How should we refer to her? Which label fits best? Should we label her according to our primary role when we are with her? Which label helps us to see her holistically? What do you think she would prefer?*

# People First Language\*

36

The disability rights movement has provided us with an objective way to communicate about individuals without reducing them to being just about *one* aspect of themselves.

People First Language eliminates generalizations, assumptions and stereotypes by focusing on the person rather than the disability.

As the term implies, People First Language refers to the individual first and the disability second.

It's the difference between saying “the mentally ill” and “a person with mental health concerns.”

# People First Language continued

37

People First Language is used to tell what a person HAS, not what a person IS.

It emphasizes abilities not limitations.

It avoids negative words that imply tragedy, such as afflicted with, suffers, victim, prisoner and unfortunate.

It promotes understanding, respect, dignity and positive outlooks.

\*Adapted From the Texas Council for Developmental Disabilities

# Examples of People First Language

38

People First Language	Labels that Stereotype or Devalue
Person with a disability	The handicapped, the disabled
Person without a disability	Normal or typical person
Person with a mental illness, person who has an emotional or psychiatric disability	Mentally ill, emotional disturbed, insane, crazy, demented, psycho, maniac, lunatic
Person with an intellectual or cognitive disability	Mentally retarded, retarded
Person who uses a wheelchair or who has a mobility impairment	Wheelchair bound, confined to a wheelchair, crippled
Accessible bathrooms, buses, parking	Handicapped bathrooms, buses, parking
Person who has experienced domestic violence	Victim

# Talking about Mental Health

39

Now that we have covered the issue of labels, we are going to cover how to talk to someone about how their experiences with DV and trauma may have impacted their mental health.

This conversation should take place ***after*** a survivor has been accepted into services by your organization and is clear that they are welcome to access services. It also helps to have the conversation after you have established some trust and rapport with the survivor.

Ideally this conversation should take place with all of your adult program participants.

# Providing Context

40

Below and on subsequent slides are some suggestions about talking about mental health issues related to experiencing trauma and domestic violence.

You can start by providing some context by saying something like...

*I want to share some information about the impact of trauma and talk with you about your experiences, so we can offer you support. If there is something that I am talking about that is not clear or I am not explaining well, I want you to feel OK asking a question at any time.*



# Talking about Mental Health

You may wish to say something like...

*Many survivors of domestic violence experience a significant amount of emotional distress. Some people become overwhelmed to the point of not being able to take care of every day demands. Others cope very well for a time, but over a longer period of enduring stress find that they are no longer coping as well as they were previously.*

*It is common for people to experience a whole range of emotions and physical complaints following a traumatic event or living through an ongoing traumatic situation.*

# Trauma Response – Physical Problems

42

*There is a range of responses related to trauma.*

*Some people have physical problems such as:*

- *Difficulty sleeping*
- *Loss of appetite*
- *Sore tense muscles or muscle pain*
- *Headaches*
- *Unexplained digestive problems, such as stomach aches*

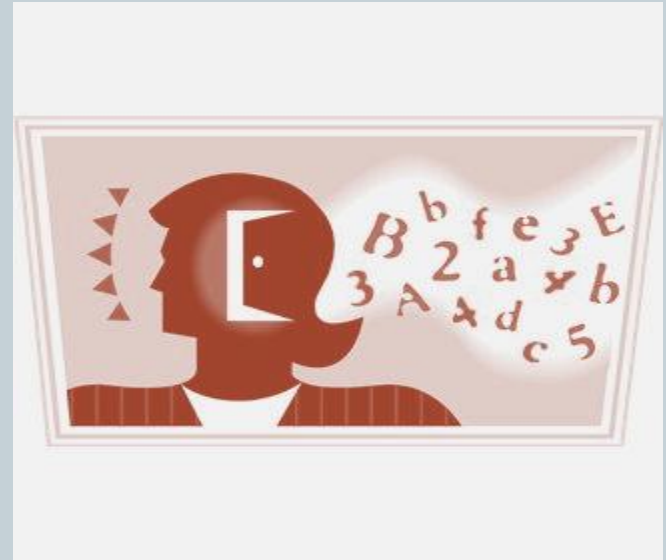


# Trauma Response – Cognitive Problems

43

*Some people have cognitive problems such as:*

- *Difficulty concentrating or thinking*
- *Problems with memory*
- *Difficulty communicating or expressing yourself*
- *Difficulty with comprehension or making sense of what others are saying*



# Trauma Response – More Examples

44

- *Some people have problems with making decisions, or with their judgment*
- *Many people feel sad or depressed, but some people express feelings of hopelessness, overwhelming sadness, or even thoughts of harming themselves or harming someone else, or other scary thoughts*
- *Some people feel agitated and irritable, some feel unable to control anger*
- *Some people do things to survive the abuse that lead to feelings of guilt or shame later*

# Questions to Facilitate Conversation

45

Here are some sample questions to facilitate conversation about mental health.

You do not need to ask all of them. Select the ones you feel are the most appropriate for the particular survivor's situation and adapt them to fit your own style of speech.

However, be sure to ask about suicidality.

- *Does any of this sound familiar to you? Have you experienced anything like what I have been talking about?*



# Questions continued

46

- *Tell me about how you sleep. Are you not sleeping as well as you used to? Do you have trouble staying asleep? Are you sleeping too much?*



- *Has your mood changed? Do you find yourself easily irritated? Have you been crying a lot?*

# Questions continued

47

- *Are you having any difficulty thinking clearly? Are you having difficulty with your memory? Do you find yourself preoccupied with disturbing thoughts?*



- *Do you ever feel depressed? Hopeless? Do you ever think about suicide? Do you ever think about hurting or killing yourself?*

# Responding to Disclosures

48

- Use your advocacy and active listening skills to respond to disclosures of mental health concerns.
- Reflect that you have heard what they have shared and validate that it is understandable to experience mental health concerns in response to trauma.
- If a survivor disclose self-harm or thoughts of suicide, be sure to follow the steps covered in lessons 3 and 4.
- Check the flowchart to determine your next step after you get a sense of what the survivor is experiencing.