Disclaimer and Funding Statement

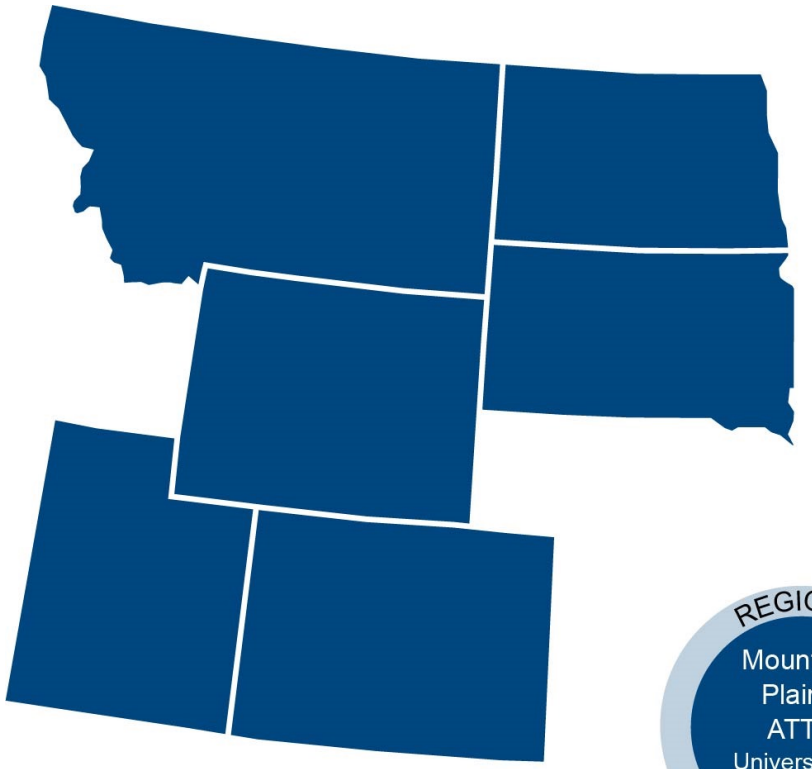
At the time of this presentation, Tom Coderre served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of the Mountain Plains ATTC and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

The work of the Mountain Plains ATTC is supported by grant TI080200_01 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

The Mountain Plains Addiction Technology Transfer Center

The Mountain Plains Addiction Technology Transfer Center (Mountain Plains ATTC) supports and enhances substance use disorder treament and recovery services for individuals and family members throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



REGION 8
Mountain Plains ATTC
University of North Dakota

Evaluation Information

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

At the end of today's training, you will be directed to a website to complete a complete a **brief** survey about today's training.

The use of affirming language inspires hope and advances recovery.

LANGUAGE MATTERS.

Words have power.

PEOPLE FIRST.

The ATTC Network uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices.

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Language Matters

Language is powerful – especially when talking about addictions.
Stigmatizing language perpetuates negative perceptions.

"Person first" language focuses on the person, not the disorder.

When Discussing Addictions...

SAY THIS	NOT THAT
Person with a substance use disorder	Addict, junkie, druggie
Person living in recovery	Ex-addict
Person living with an addiction	Battling/suffering from an addiction
Person arrested for drug violation	Drug offender
Chooses not to at this point	Non-compliant/bombed out
Medication is a treatment tool	Medication is a crutch
Had a setback	Relapsed
Maintained recovery	Stayed clean
Positive drug screen	Dirty drug screen

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.

Trauma in the Context of Interpersonal Violence: a Systems Response

Marvis Doster, CARN
Tracy Evanson, PhD, RN, PHNA-BC
Chris Harsell, DNP, ANP-BC
Thomasine Heitkamp, LCSW
Kim Miller, LMAC/LPCC
Maridee Shogren, DNP, CNM, CLC

Mountain Plains ATTC (HHS Region 8)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

SAMHSA
Substance Abuse and Mental Health Services Administration

Tracy Evanson

Dr. Tracy A. Evanson is a Professor at the University of North Dakota and member of the Mountain Plains ATTC team. Dr. Evanson has an extensive background in intimate partner violence (IPV), working with women and children survivors in shelters, corrections, and home settings. She has previously served as a Board Member and Vice President of the Nursing Network on Violence Against Women, International (NNVAWI), the primary international nursing organization dedicated to eliminating violence against women. Dr. Evanson has expertise in qualitative research, and her focus of research is IPV, specifically related to rural populations. In 2016, she received the Outstanding Researcher Award from NNVAWI. She also teaches several graduate courses related to rural health and rural populations. Dr. Evanson is a first-generation college graduate and grew up in a rural North Dakota community of about 200 people. She is the lead author on the new ATTC product entitled, *Rural Intimate Partner Violence Survivors and Substance Use Disorders: Implications for Treatment and Recovery Support Providers.*

Intimate Partner Violence (IPV) Defined

- A systematic pattern of learned behaviors that a person uses to control, dominate, or coerce a current or former intimate partner.
- The behaviors occur over time and are likely to become more frequent and severe.
- Includes physical, psychological, and sexual abuse, stalking, coercion related to mental health and substance use, as well as destruction of property and pets.

Power and control is what drives the behaviors

Who are victims/survivors?

Approximately 1 in 4 women and nearly 1 in 10 men have experienced sexual violence, physical violence and/or stalking by an intimate partner in their lifetime and reported some type of IPV-related impact (Smith et al., 2018)

IPV in Rural Populations

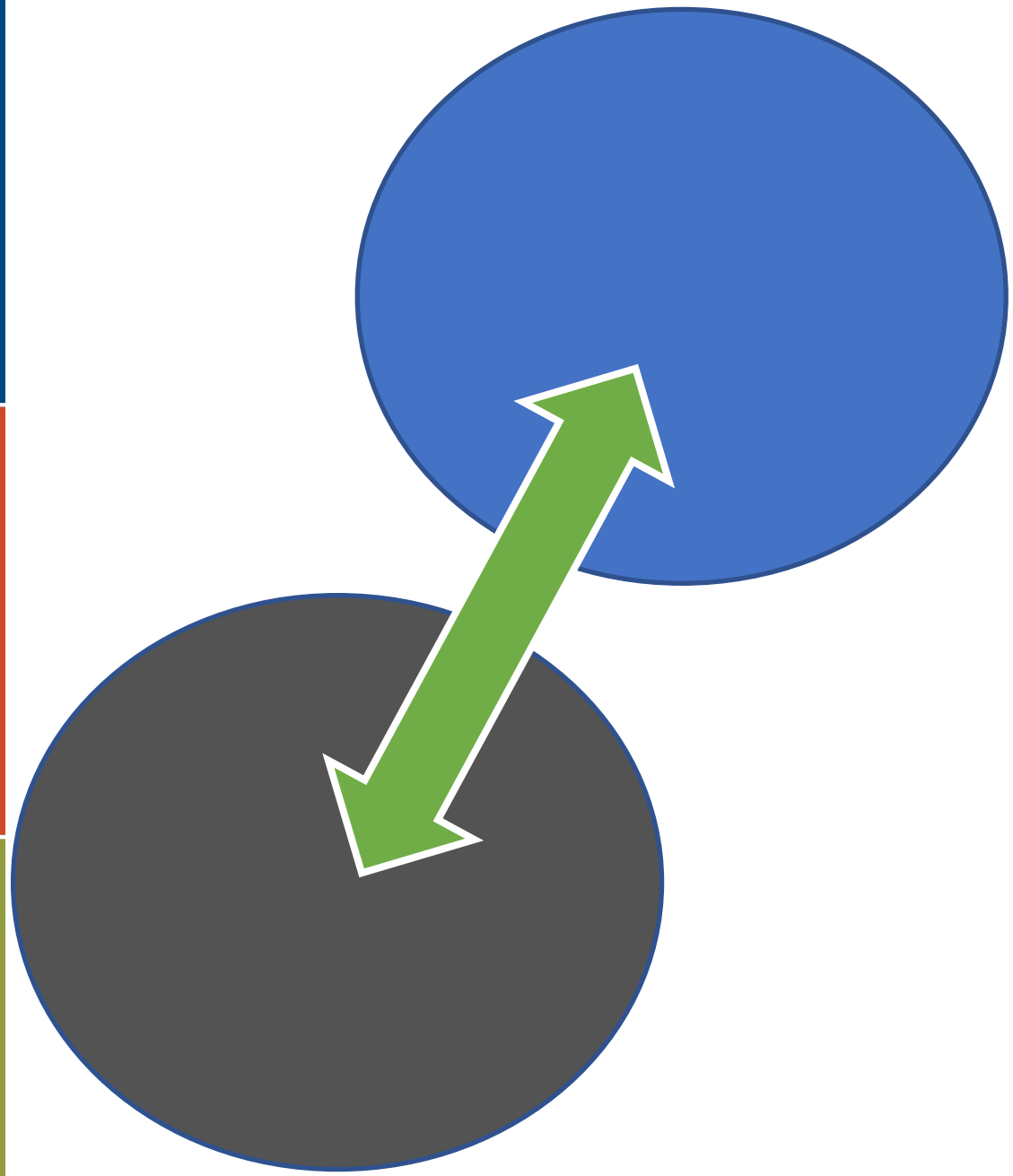
- IPV in rural areas is as high or higher than in non-rural
  - One frequently cited study (Peek-Asa et al., 2011) found:
    - Women in small rural and isolated areas had the highest prevalence of IPV (22.5% and 17.9% respectively) compared to 15.5% among urban women
    - Rural women had significantly greater severity of physical abuse than urban women
  - Femicide (murder of a female by an intimate partner)
    - Higher in rural counties than non-rural (Beyer, 2013; Gallup-Black, 2005)

The Co-Occurrence of IPV and SUDs

- Among women survivors of IPV
  - 18-72% report substance use or abuse
  - The prevalence is consistently higher when compared with persons who have not experienced IPV

- Among women with SUDs
  - 47-90% of women in SUD treatment settings report experiencing IPV during their lifetime
  - 31-67% report experiencing IPV within the past year
  - Consistently higher than the prevalence reported in national studies with the general population

Rivera et al. (2015)



IPV and SUDs Among Survivors: A Bidirectional Relationship

SUD precedes IPV

- Women with SUDs may be easier to “control”
- The effects of substances may prevent women from accurately assessing the level of danger posed by their partners
- The use of substances may cause problems with memory that can cause a woman to question what occurred

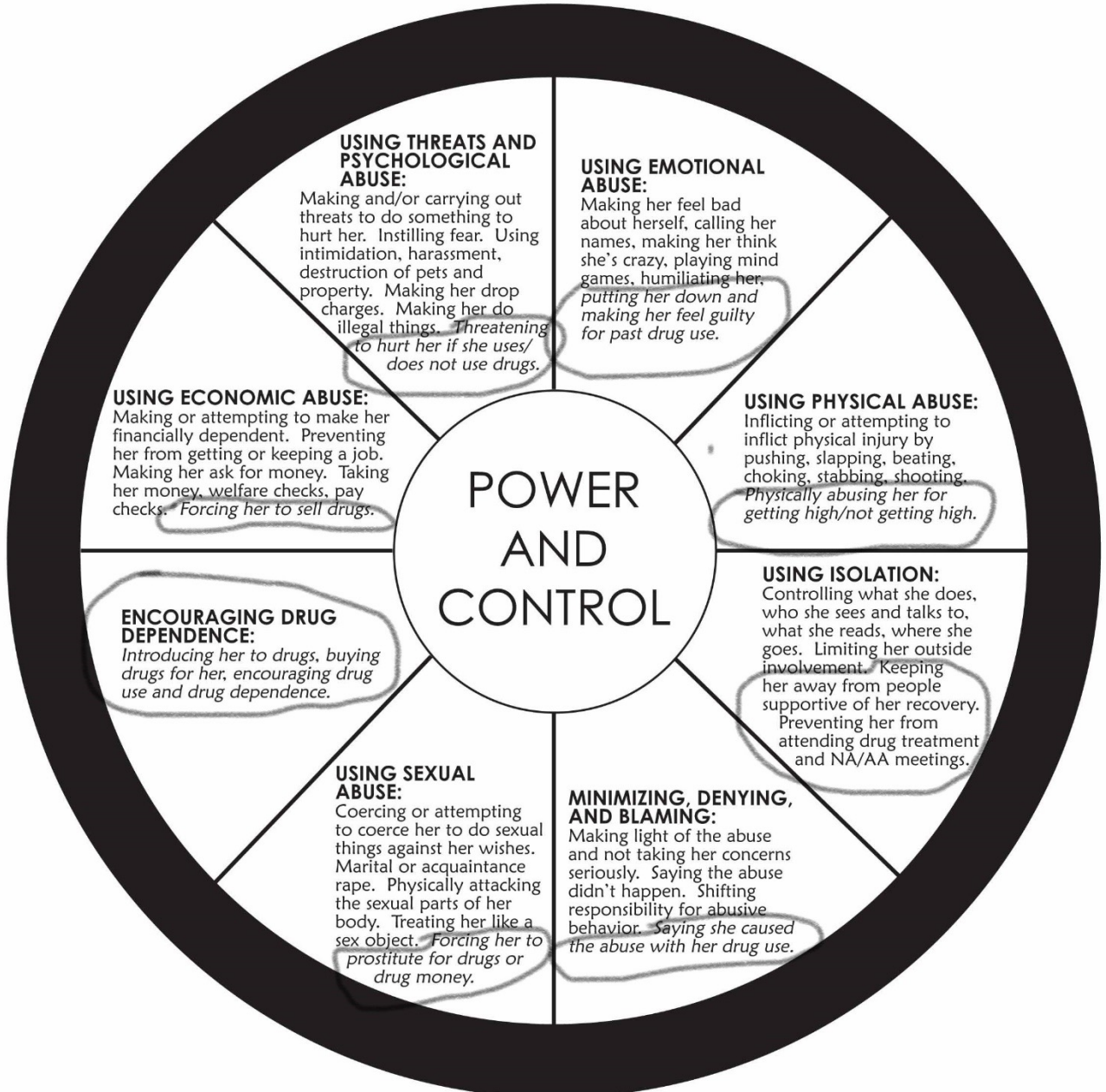
IPV Precedes SUD

- Coping
  - Psychological effects
  - Acute and chronic pain

IPV Precedes SUD

- Substance use as a method of control/coercion
  - Perpetrators may be playing a role in survivors initiating use of substances as a way to gain control, and then to maintain power and control
  - This needs to be viewed in the context of the other tactics used to dominate, coerce and control the survivor

Power and Control Model for Women's Substance Abuse



RURAL INTIMATE PARTNER VIOLENCE SURVIVORS AND SUBSTANCE USE DISORDERS: IMPLICATIONS FOR TREATMENT AND RECOVERY SUPPORT PROVIDERS

Mountain Plains ATTC (HHS Region 8)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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View this product on the Mountain Plains ATTC website: Here

Marvis Doster

Marvis Doster is a Certified Addictions Registered Nurse who has worked in North Dakota for the past 50 years. Currently, a Technology Transfer Specialist with the Opioid Response Network in association with Mountain Plains Addiction Technology Transfer Center at UND, Marvis is assigned to seven states to address opioid and stimulant issues by connecting Prevention, Treatment and Recovery consultants with organizations requesting technical assistance through a Federal SAMHSA grant. Marvis has been a national trainer for ATTC in SBIRT, Telehealth, Medication Assisted Therapy, ASAM Placement Criteria, Compassion Fatigue and Stimulant Use Disorder. Marvis has served on the Mayors Blue Ribbon Committee to address the opioid issues in the Fargo area, the Committee for Impaired Professionals for the ND Board of Nursing and is currently the Vice Chair of the ND Board of Addiction Counseling Examiners.

Principles Of Effective Treatment

- 1. Addiction is a complex but treatable disease that affects brain function and behavior.
- 2. No single treatment is appropriate for everyone.
- 3. Treatment needs to be readily available.
- 4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
- 5. Remaining in treatment for an adequate period of time is critical.
- 6. Behavioral therapies – including individual, family, or group counseling – are the most commonly used forms of drug abuse treatment.

Principles Of Effective Treatment

- 7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- 8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
- 9. Many drug addicted individuals also have other mental disorders.
- 10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.

Principles Of Effective Treatment

- 11. Treatment does not need to be voluntary to be effective.
- 12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
- 13. Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.

Chris Harsell

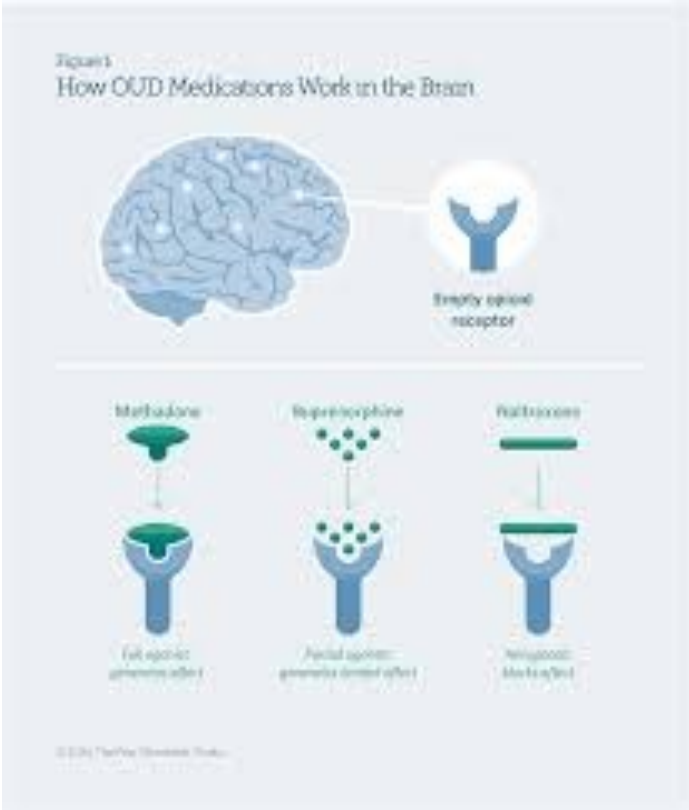
Dr. Chris Harsell is a clinical associate professor and member of the Mountain Plains Addiction Technology Transfer Center (ATTC) team. As part of the team she facilitates the opioid treatment providers work group and provides training for the region. She has worked as a primary care NP for 15 years and serves as medical director of a federally qualified health center (FQHC) that offers integrated behavioral health and Level 1 addiction services. She worked with a team at the FQHC to develop the only primary care office-based MAT program in the area and is a waivered MAT prescriber. Through her work with clients and SUD, she has become a HUGE FAN of harm reduction and its effectiveness in walking with people towards recovery.

SUD “The Basics”

- SUD is a chronic brain disease
- Screening for SUD should be a routine part of practice
- People are dying
- There is evidence-based treatment
- It takes a village - No one discipline, or agency or person can solve this issue
- You already know about MAT

- **Medication-Assisted Treatment (MAT)**
  - The use of medications and behavioral therapies to treat substance use disorders.

- **Outcomes:**
  - Reduces illicit drug use
  - Reduces overdose deaths
  - Decreases transmission of infectious diseases
  - Decreases criminal activity
  - Increases social functioning and retention in treatment
  - Improves fetal outcomes



HARM REDUCTION

- Strategies that aim to reduce the harmful consequences associated with high-risk activities
- An act of empathy

Harm Reduction Examples

- **Infection Control**
  - Condoms/Dental Dams (prevents STD transmission)
  - Pre-Exposure Prophylaxis (PrEP) Medication (significantly decreases HIV transmission)
  - Syringe Service Programs (prevents HIV and HCV transmission)
- **Accident/Injury Prevention**
  - Sunscreen
  - Seatbelts
  - Designated Drivers (decreases incidence of MVA)
  - Limiting Intake (decreases incidence of accidents, overdose and death)
- **Overdose Prevention**
  - Naloxone (reverses overdose, reduces mortality)
  - Medication Assisted Treatment: Combines medications with behavioral therapy to treat SUD (decreases incidence of overdose, reduces mortality, improves QOL)
  - Safe Injection Sites (decreases incidence of overdose and death)

Maridee Shogren

Dr. Maridee Shogren is a Clinical Professor at the University of North Dakota, Certified Nurse-Midwife and Certified Lactation Counselor. She has extensive knowledge regarding rural health systems, the use of SBIRT and interprofessional education and training. She works with the Region 8: Mountain Plains Addiction Technology Transfer Center and the Mountain Plains Mental Health Technology Center grant teams housed at UND. Her areas of expertise on the grant teams include SBIRT, for general populations as well as pregnant women and adolescents; substance exposed mothers and infants; peripartum depression; stigma and women with substance use disorders; and farm stress. Most recently, she has begun work as the principal investigator on the Foundation for Opioid Response Efforts grant funded program, Don't Quit the Quit, where she is working to increase access to treatment and care, enhance community education about substance use disorders, and grow community awareness and support for women who are pregnant or postpartum and in recovery from opioid use disorder.

Treatment of SUDs During Perinatal Period

- Prenatal care + social services+ SUD treatment= Harm Reduction and Comprehensive Care
  - Pregnancy provides “Window of Opportunity” to engage in SUD treatment
  - Universal screening for SUDs and IPV should be conducted during pregnancy & postpartum care
- Medications to Treat Opioid Use disorder (MOUD)* are the gold standard of care for treatment: **This should NOT be altered by pregnancy!**
  - MOUD can be started any time during pregnancy, postpartum (includes breastfeeding)
  - MOUD is NOT associated with an increased risk of birth defects, structural abnormalities (SAMHSA, 2018)
  - MOUD CAN
    - Lower risk of OB complications
    - Improve maternal nutrition
    - Improve infant birth weight (SAMHSA, 2018)
  - Pregnant persons with OUD should NOT be encouraged to withdraw from MOUD during pregnancy or shortly after delivery!
    - Withdrawal associated with high rates of recurrence of use (59-90%) and poorer outcomes, including accidental overdose (loss of tolerance)

*Methadone or Buprenorphine products

Reproductive Health

- Once a woman engages in treatment for SUD/OUD, it can be a perfect time to address reproductive health needs
  - More consistent care pattern often seen
  - Insurance coverage may be available during pregnancy/postpartum
  - Already working on healthier lifestyle choices
- Reproductive health: state of complete physical, mental and social well-being, not just the absence of disease or sickness, in all matters relating to the reproductive system, its functions & processes…includes sexual health (World Health Organization, 2021)
- Reproductive Health comes with Reproductive Rights
  - The right of all individuals and couples to
    - Information
    - Education
    - Choice about number and timing of one's births (Family Planning)
    - Attainment of the highest level of reproductive health (World Health Organization, 2021)

Reproductive Health

- Unfortunately, many women with SUDs during the perinatal period experience coercion, discrimination, and violence surrounding reproductive health
- Coercion
  - May have experienced unsafe sexual behaviors or trafficking in return for substances
- Discrimination
  - Not being provided contraception education or choice based on sex, gender identity, race…or SUD history
- Violence (Perinatal Intimate Partner Violence [PIPV])
  - Experiences of violence that occur in the year before pregnancy, during pregnancy, and up to one year postpartum
  - 3.7%-9% of women experience PIPV
  - Women who report perinatal IPV are at increased risk to use alcohol, nicotine, and drugs compared to women who do not report IPV

IPV/PIPV and Reproductive Health Consequences

Sexual Reproductive	Pregnancy/Maternal Health	Neonatal Outcomes
Lower rates of contraceptive and condom use	Less likely to initial prenatal care at all or initiate late in third trimester	Low birth Weight
Unintended/unwanted pregnancy	Poor nutrition & inadequate gestational weight gain	Preterm birth
Abortion/unsafe abortion	Increased risk of SUDs	Increased risk of perinatal death (fetal loss after 20 weeks gestation) & neonatal death (occurring ≤ 28 days after delivery
Sexually transmitted infections, including HIV	Increased risk of miscarriage	Potential for insecure attachment, poorer maternal/infant bonding Inadequate stimulation & play Failure to thrive
Pregnancy complications and miscarriage	Increased risks of physical trauma like vaginal bleeding, hemorrhage, or placental abruption	Less likely to be breastfed or shorter duration of breastfeeding
Vaginal bleeding or infections	Increased risk of perinatal depression (40% of abused women report)	Potential for NAS/NOWS if experienced prenatal substance exposure
Chronic pelvic infection	Maternal injury: 54% of pregnancy-associated suicides involved IPV 45% of pregnancy-associated homicides involved IPV	
Urinary tract infections	Negative coping behaviors	
Fistula (a tear between the vagina and bladder, rectum, or both)		
Painful sexual intercourse		
Sexual dysfunction		

Alhusen et. al.(2015); RURAL INTIMATE PARTNER VIOLENCE SURVIVORS AND SUBSTANCE USE DISORDERS: IMPLICATIONS FOR TREATMENT AND RECOVERY SUPPORT PROVIDERS. (2021).

Thomasine Heitkamp

Thomasine Heitkamp is the PI and Co-Director of Mountain Plains Addiction Technology Transfer Center (ATTC) and Mountain Plains Mental Health Technology Transfer Center (MHTTC), and a Chester Fritz Distinguished Professor at the University of North Dakota. She brings expertise as an educator and former child welfare practitioner. She has taught both graduate and undergraduate social work courses on family violence and child welfare. Professor Heitkamp has authored a host of peer-reviewed publications and also serves as a co-author on the new ATTC product entitled *Rural Intimate Partner Violence Survivors and Substance Use Disorders: Implications for Treatment and Recovery Support Providers*. Her academic efforts include expanding access to use of technology to enhance capacity among the behavioral health workforce in tribal and rural communities.

IPV and Children

- Exposure to IPV for children includes hearing, witnessing, and intervening during an incident as well as witnessing the impact on the mother after the incident (Kitzmann, 2003). Includes direct involvement, as direct eye witnesses, and indirect exposure.
- Engagement with child welfare professionals can be meet with resistance as women worry their children will be removed. 35% of IPV victims did not ask for support because they were worried about engagement with child protection services. (Lippy, et al, 2019)
- Impact on children underscores the critical importance of trauma informed care for families.

Frequency and Impact

- One out of four children (25%) 14-17 year olds have witnessed a parent assault another parent in their lifetime (Finkelhor et al, 2015)
- 73% of the women who experience IPV are mothers.
- Impact of exposure to domestic violence on children varies (remember children can move forward from stressful events). IPV can include experiencing symptoms and lasting effects of post traumatic stress disorder (PTSD). Symptoms could include:
    - Insomnia,
    - Irritability,
    - Poor concentration,
    - Memory impairment,
    - Startles easily,
    - Feelings of detachment,
    - Feeling unsafe.

Possible Reactions to IPV by Developmental Stage

Birth to 5

- Sleep and/or eating disruptions
- Withdrawal/lack of responsiveness
- Intense separation anxiety
- Inconsolable crying
- Developmental regression, loss of acquired skills
- Intense anxiety, worries
- Increased aggression and/or impulsive behavior
- https://www.nctsn.org/what-is-child-trauma/trauma-types/intimate-partner-violence/effects

Ages 6 to 11

- Nightmares, sleep disruptions
- Aggression and difficulty with peer relationships in school
- Difficulty with concentration and task completion in school
- Withdrawal and/or emotional numbing
- School avoidance and/or truancy

Ages 12 to 18

- Antisocial behavior
- School failure
- Impulsive and/or reckless behavior,
- School truancy
- Substance abuse
- Running away
- Involvement in violent or abusive dating relationships
- Depression
- Anxiety

Consider System-wide Prevention and Intervention Approach

Interventions:

Work to ensure/re-establish a parental relationship with the non-offending parent

Access to:

- Trauma focused cognitive behavioral therapy https://www.nctsn.org/interventions/trauma-focused-cognitive-behavioral-therapy
  - Trauma Informed System of Care
- Case management service
- Increase safety (housing programs)
- Advocacy services
- Community policing program https://www.nctsn.org/sites/default/files/interventions/cdcp_fact_sheet.pdf
- Engagement in culturally responsive practice https://mhttcnetwork.org/centers/mountain-plains-mhttc/product/strengthening-resilience-promoting-positive-school-mental

Prevention: https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

Consider the Following

- Teach safe and healthy relationships
- Engage influential adults as peers
- Create protective environments
- Strengthen economic supports for families
- Disrupt the developmental pathways towards domestic violence

Tami DeCoteau content 3-19-21:

https://mhttcnetwork.org/centers/mountain-plains-mhttc/product/trauma-and-intimate-partner-violence

Kim Miller

Kim Miller is a Licensed Master Addiction Counselor and Licensed Professional Clinical Counselor with over 30 years of clinical experience working with substance use disorder and mental illness. She supervised a women's residential treatment program for over ten years and was the program supervisor at NEHSC where she developed co-occurring treatment programs for both outpatient and residential adult clients. She is trained and experienced in using evidenced based programs for substance use disorders and trauma. Kim is also the director of the Red River Valley/UND Addiction Counselor Training program and has been supervising addiction counselor trainees for over 20 years. She is a graduate of the University of North Dakota and the University of St. Francis. Kim is the associate project director for the Mountain Plains ATTC.

Trauma and SUD Triggers

- Smells
- Sounds/Music/TV Shows/Movies
- People (Family Members, Dealers, Police)
- Places (Bars, Neighborhoods, Car, Apartment)
- Things (Needles, Foil, Pens)
- Dates/Holidays/Anniversaries (Deaths or significant events)

Good News!

- Skills learned to cope with trauma triggers can be used to cope with using triggers
- Lots of options are available for learning new skills
- Many are simple to use/practice/teach
- Phone Apps: Calm, Headspace, Calm Harm, MyLife, Insight Timer and apps for DBT/CBT, sobriety apps – 12 Steps/Daily Meditation
- Seeking Safety treatment – Lisa Najavits
- Dialectical Behavior Therapy for Substance use - DBTS

Emotional Regulation/Grounding/Distract

- 4 Square Breathing
- 5, 4, 3, 2, 1 – Things I can see, hear, touch, smell and feel
- Change Body Temperature – go outside, wash hands or dishes
- Soothing sounds/music
- Quiet space – reduce stimulation
- Rocking, warm blankets – self soothing
- Distract with shows/TV that elicit opposite emotion – something funny for example

Suggestions For Residential Staff

- Be aware of your own emotional responses – you are a role model for managing emotions
- Be Consistent and calm, even when you are experiencing your own strong emotions – self care is necessary! Compassion Fatigue
- Talk to clients about plans to help them cope ahead of time – ask them how you can help if they are dysregulated, help them identify options they are comfortable with – night terrors can be an issue
- Be aware of potential boundary issues, either too low or too high – consistency with rules and expectations help

Affirming Language Inspires Hope and Advances Recovery…

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