Screening, Assessment, and Intervention Model for Intimate Partner Violence Perpetration and Co-Occurring Combat-Related Conditions

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EXECUTIVE SUMMARY

The United States was at war in Iraq and Afghanistan for over a decade. Over 2.7 million people served in one or both of these war zones, including an unprecedented number of National Guard and Reserve personnel. Many experienced multiple deployments, extended tours, and decreased breaks from combat. The veterans of these deployments return to their spouses, children, families, and communities with visible and invisible injuries, such as combat-related post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). A small but growing number are becoming involved with the criminal justice system for a range of crimes, including intimate partner violence (IPV).

In communities across the country, medical facilities, social services, criminal justice systems, and courts are grappling with how to effectively serve this population of returning service members and their families. The variety of intervention points by which IPV victims and offenders engage with these agencies requires a broad and coordinated approach to screening, assessment, and intervention that results in early identification of co-occurring conditions related to combat experience, so that subsequent interventions are appropriate, just, and effective.

Combat experience certainly represents a source of significant traumatic stress and injury for individuals. However, it's important to note that the general population of IPV perpetrators who have never been in the military often have significant trauma histories and also exhibit co-occurring conditions such as PTSD, TBI, substance abuse, depression, and other mental health conditions. Comparing the general population of IPV perpetrators without a military background and military veterans, the rate of IPV perpetration is higher among military veterans, but the dynamics and risk factors are more similar than different (Taft, Watkins, Stafford, Street, & Monson, 2011).

This guide presents a model for understanding IPV and its relationship to co-occurring combat-related conditions and recommends a community-wide approach to screening, assessment, and intervention for IPV perpetration and co-occurring conditions. Implementation of these recommendations will allow communities to intervene more effectively in these cases to prevent further violence in military and veteran families.

Recommendations

The following recommendations address screening, assessment, and intervention when IPV perpetration involves military personnel and veterans and is present with co-occurring conditions. Since this guide focuses on IPV perpetration and combat-related co-occurring conditions, it does not specifically address recommendations for screening and assessing for victimization or intervening with IPV victims.

All Points of Intervention: Military and Veteran Specific Information

- Incorporate awareness of, and sensitivity to, military and veteran culture into training for all interveners.
- Screen routinely for military experience, war-zone deployments, and combat experience.
- Screen for co-occurring conditions such as PTSD, TBI, substance abuse, and depression.
- Have protocols in place for more in-depth assessment and/or refer when there is a positive screen.
- Develop collaborative relationships with military installations and Department of Veterans Affairs (VA) facilities.

- Create memoranda of understanding to address information sharing between military, veteran, and community-based agencies/programs.

Best Practice for All IPV Cases: Law Enforcement and Criminal Justice System

- Participate in a coordinated community approach to responding to IPV.
- Obtain demographic information on IPV perpetrators.
- Screen routinely for a criminal and/or court history.
- Screen routinely for a protection order history.
- Screen routinely for presence of and access to weapons.
- Screen for risk factors for re-offense in IPV cases.
- Assess for and monitor ongoing risk/danger/lethality in IPV cases.
- Screen routinely for a history of IPV victimization and perpetration and have protocols in place for more in-depth assessment and/or refer when there is a positive screen.
- Conduct a contextual analysis to determine the larger context in which the IPV is embedded to inform ongoing risk and danger assessment and safety planning, as well as decisions about appropriate intervention.
- Screen every IPV perpetrator for:
    - Depression and suicidal/homicidal thinking and intent
    - Substance abuse
    - PTSD and TBI
- Have protocols in place for more in-depth assessment and/or refer when there is a positive screen.
- Assess for immediate danger and have protocols in place to respond to situations of imminent threat.

Best Practice in All IPV Cases: Community Programs (including Department of Defense (DoD) and VA facilities)

- Participate in a coordinated community approach to responding to IPV.
- Screen for abuse history, both victimization and perpetration, and have protocols in place for more in-depth assessment and/or referral when there is a positive screen.
- Conduct a contextual analysis to determine the larger context in which the IPV is embedded to inform ongoing risk and danger assessment and safety planning, as well as decisions about appropriate intervention.
- Identify the types and patterns of abuse and abusive tactics.
- Determine the frequency and severity of the IPV.
- Assess for and monitor ongoing risk/danger/lethality in all IPV cases.
- Assess for immediate danger and have protocols in place to respond to situations of imminent threat.
- Provide in-depth assessments for mental health and substance abuse issues when there is a positive screen for IPV victimization and/or perpetration or refer to a qualified provider when appropriate.

- Provide in-depth assessments for deployment/combat-related PTSD, TBI, and depression in military personnel and veterans when there is a positive screen or refer to a qualified provider when appropriate.

Best Practice for Intervention: Community Programs (including DoD and VA Facilities)

- Incorporate awareness of, and sensitivity to, military and veteran culture into training and programming for all interveners.
- Participate in a coordinated community approach to responding to IPV.
- Develop collaborative relationships with military installations and VA facilities.
- Create memoranda of understanding to address information sharing between military, veteran, and community-based agencies/programs.
- Assess every IPV perpetrator for depression and suicidal/homicidal thinking and intent and have protocols in place for more in-depth assessment and/or referral as needed.
- Assess every IPV perpetrator for co-occurring conditions such as PTSD, TBI, and substance abuse and have protocols in place for more in-depth assessment and/or referral as needed.
- Conduct a contextual analysis to determine the larger context in which the IPV is embedded to inform ongoing risk and danger assessment and safety planning, as well as decisions about appropriate intervention.
- Assess for immediate and ongoing danger and have protocols in place to respond to situations of imminent threat.
- Provide specific, concurrent interventions for each co-occurring problem and ensure that providers have specific subject matter expertise in the areas being addressed.
- Provide specific offender intervention programs to confront and eliminate perpetrators' use of violence in intimate relationships.
- Involve battered women's programs, the courts, the military, the VA, and other providers to explore developing military and veteran-specific IPV offender intervention programs and consider potential unintended consequences.
- Develop and implement clear policies and guidelines for handling information divulged by partners and err on the side of caution when deciding about the propriety of using the information.
- Implement and follow clear policies and guidelines for use of couples/marriage counseling in IPV cases to ensure victim safety.

MODEL FOR UNDERSTANDING INTIMATE PARTNER VIOLENCE PERPETRATION AND COMBAT-RELATED CO-OCCURRING CONDITIONS

Context of Violence

Anyone who works with intimate partner violence (IPV) survivors knows that not all incidents are the same; each incident occurs within a larger context. Examining the context of the violence requires going deeper than just the incident to the history and obtaining information about the intent, meaning, and effect of the violence. Knowing the context of the violence clarifies what a person is experiencing, helps to determine the level of risk and danger, and informs appropriate interventions and safety planning. This is important when incidents involve people with no military connection as well as military personnel and veterans and their families.

To provide the most effective response to each victim, it is crucial to uncover the particular context in which the abuse is embedded. This is important because:

- Different risks are associated with different histories of violence or particular behaviors exhibited by the perpetrator (Campbell, 1995; Johnson, 2008; Leone et al., 2004).
- Safety planning will not be effective unless it takes into account the different forms of coercion or violence present in each situation. Is the victim being stalked? Have there been threats to take the children? Does the perpetrator have access to a weapon? Does the perpetrator use other family members to enforce control over the victim?
- The interventions available from the courts or social services will be more or less helpful, or more or less risky, depending on the context of the violence.

Grouping all acts of violence together distorts the understanding of who is doing what to whom, with what intent and effect, and who needs protection from whom. It is important to understand the answers to these questions to know which community interventions might be effective in holding the perpetrator accountable for ending the violence and in enhancing the victim's safety. Misunderstandings about the context of the violence can have dangerous or even fatal consequences, as indicated by analyses of intimate partner homicides (Campbell J. C., et al., Assessing risk factors for intimate partner homicide, 2003a).

Current research indicates four contexts in which IPV takes place that have significant implications for interventions. These contexts have been identified as: 1) IPV with coercive control 2) resistive violence in response to IPV with coercive control 3) IPV without coercive control - situational IPV and 4) IPV related to mental illness, substance abuse, or brain injury. The first three contexts correspond to the typology developed by Michael P. Johnson, in his book, *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence* (Johnson, 2008), and subsequent research. However, the terms "IPV with coercive control" and "IPV without coercive control" have been substituted for his terms: "intimate terrorism" and "situational couple violence" in order to emphasize that the identification of the presence of coercive tactics is key to the development of an effective response (Dutton & Goodman, 2005). The first two contexts are particularly important to assess accurately because of their association with higher levels of lethality, injury, and victim entrapment. The potential for further harm is exacerbated when community programs and institutions fail to identify these dynamics and intervene inappropriately.

IPV with Coercive Control

In the 1970's, women began to publicly protest the fact that cultural attitudes and existing laws facilitated violence by husbands against their wives, and discouraged outside intervention into what was considered a "private" matter. Shelters were established to provide temporary housing and aid to women fleeing violent relationships. Early advocates used the term "battering" and described the behavior reported by many of their residents as an ongoing pattern of coercion, intimidation, isolation, and emotional abuse in their intimate relationships, reinforced by the use and threat of physical and/or sexual violence. The Power and Control Wheel, Figure 1 (Domestic Abuse Intervention Programs, 2013), graphically captured this phenomenon, and the wheel's subsequent use and adaptation by women's groups around the world demonstrates how effectively it portrays their experience.

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The terms “domestic violence,” “domestic assault” and “domestic abuse” gradually replaced “battering” especially in statutory language. However, these terms include acts committed by any co-habitant or family member, as well as acts of resistance committed by a victim against the perpetrator. Researchers, experts, and those working in the field have begun instead to use the term *intimate partner violence***,** which has the advantage of excluding violence outside of adult intimate or romantic relationships, while including same-sex relationships.

For the purposes of this document, the term *IPV with coercive control* is used to denote the patterned behavior occurring in an adult intimate relationship that was described in the original term “battering,” as represented by the Power and Control Wheel. IPV with coercive control is a strongly gendered phenomenon that in heterosexual relationships is perpetrated largely by men (Catalano, 2007; Johnson, A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence, 2008; Johnson, Gender and types of intimate partner violence: A response to an anti-feminist literature review, 2011; Klein, Wilson, Crowe, & DeMichele, 2005`).

Relationships are complex. Even in the healthiest relationships, intimate partners may seek control to some extent as relationships necessarily involve mutual influence, negotiation, and compromise. However, in IPV with coercive control, the perpetrator intentionally uses violence and other coercive behaviors to establish and maintain control over the partner for the long-term. Although each particular act of intimate violence may have any number of short-term, specific goals, the violence is embedded in a larger pattern of coercive control that permeates the relationship. The nonviolent tactics that accompany that violence take on a new, powerful, and frightening meaning: controlling the victim not only through these specific constraints, but also through their association with the general knowledge that the partner will do anything to maintain control of the relationship, even attack physically. Most obviously, the threats and intimidation are more real and powerful if there has been previous physical and/or sexual assault.

Key elements that distinguish coercive control include: getting someone to do what you want by using or threatening negative consequences for noncompliance; making it clear that punishment will be imposed if “necessary;” surveillance and monitoring of the victim’s behavior; and attempts to wear down resistance (Dutton & Goodman, 2005). The use of IPV with coercive control is intended to entrap the partner and limit actions to those determined by the offender (Stark, 2012). Some perpetrators express an acceptance of the use of violence, especially in pursuit of perceived entitlement and traditional gender role expectations or even hostile attitudes toward women. For some perpetrators, the motivation to control their partner is associated with emotional neediness, jealousy or desperation; for others, antisocial and domineering attitudes pervade their relationships in general, including intimate relationships.

The effects of IPV with coercive control on victims include: physical injuries, (with increased likelihood of severe injury), stress-related health problems; psychological issues such as fear and anxiety, depression and post-traumatic stress; and disruption of school or job performance, and economic dependence or entrapment. All of these can erode the victim’s ability to confront the violence and take protective action. Regardless, despite the abuser’s sustained efforts to undermine them, most victims persist in seeking help and managing their daily lives, and the lives of their children, against impossible odds.

Most victims of IPV with coercive control, who understand the serious problems their partners’ coercive control causes, take action to resist the perpetrator’s control or protect themselves, and, when

necessary, end these relationships. However, perpetrators often make separation particularly difficult and are more likely to react to attempts to separate with further violence, stalking, and controlling

> ***Assessment Tip:** It is important to explore questions about whether the elements of coercive control are present in the relationship, how they are expressed (tactics), and what they mean to the victim. This is the only way to assess if the violence is occurring in this context. Because IPV with coercive control is a pattern of behavior, a particular incident of violence alone will not indicate if IPV with coercive control is present. Dialogue with victims is critical to understand the context of the violence and the danger. It is also important to educate victims about the controlling tactics related to the pattern of IPV and its increased risk of lethality and injury. Victims should be encouraged to remain alert to feelings of coercion or manipulation and be concerned if it is necessary to change behavior chiefly to avoid unpleasant negative responses or threats from the partner.

tactics. Separation may be viewed as the victim's ultimate defiance of the partner's authority, which results in attempts to reclaim this authority by any means. Indeed, some victims of IPV with coercive control do not experience a physical attack until they threaten or attempt to separate from their partners (Campbell J. C., 1992). Post-separation, these tactics continue and complicate parenting and custody arrangements, often resulting in prolonged litigation or years of harassment (Bancroft, 1998).

Resistive Violence in Response to IPV with Coercive Control

The term *resistive violence* refers to violence used by victims in response to IPV with coercive control directed against them. A victim who endures a continued pattern of emotional abuse, threats, and physical or sexual violence will likely strike back in some way, sometimes in self-defense, sometimes in retaliation, sometimes to pre-empt further attacks, sometimes to show the perpetrator that this treatment will not be accepted without a fight. As would be expected, resistive violence is also a gendered phenomenon, as it is largely the response of female partners to IPV with coercive control directed against them by their male partners. (Johnson, 2011)

The victim who commits acts of resistive violence is motivated by a very different intent than the perpetrator of IPV with coercive control. If fighting back when being attacked, acts of self-defense may be considered a justifiable response to violence, as defined in most state statutes. Other motivations include retaliation or defiance. Some victims talk about trying to get their partners to respond to their needs and using violence in frustration and anger. Unlike IPV with coercive control, the intent of this violence is not to dominate, and typically has little impact on their partners' behavior, nor does it result in the same level of fear or intimidation.

The effects of resistive violence can include serious injury to either party, especially if weapons are involved. If the perpetrator escalates violence in response, resistive violence can become more and more dangerous for the victim. Use of resistive violence makes a victim vulnerable to arrest and possible conviction, which can result in negative collateral consequences related to her personal life or livelihood. If the couple has children, the victim's access could be limited or custody could be lost, temporarily or permanently.

It is important to ensure that institutional responses to resistive violence are appropriate to this context and not necessarily equivalent to the response to IPV with coercive control. For example, efforts to decrease a victim's use of violence must be accompanied by efforts to increase her/his ability to protect her/himself from the abuser. If not, the abuser may feel emboldened, continued control and

violence against the victim will be facilitated, and services provided to the victim may be misguided at best and harmful at worst.

Assessment Tip: It is critical to consider the fact that the violence occurred in this context when determining how community institutions intervene and provide services to victims resisting IPV with coercive control. The inability or unwillingness to assess which party is being subjected to a pattern of coercive control leaves victims even more vulnerable to further abuse if they become less likely to turn to police, the courts, domestic violence or advocacy programs for assistance. Risk and dangerousness escalate as increasingly desperate victims resort to more lethal resistance and unrestrained perpetrators resort to more lethal violence.

IPV without Coercive Control - Situational Couple Violence

After careful assessment, if it appears that the victim's experience does not fall within the context of IPV with coercive control or resistive violence, then other contexts in which IPV is embedded need to be explored.

Some victims referred to advocacy programs assert that the violent incident was atypical, and that the couple has resolved the conflict to their mutual satisfaction. Usually, when the violence has occurred in this context, neither party is significantly fearful of the other, although the incident may have been frightening. These victims are unlikely to contact an advocacy program voluntarily but may be referred if there has been some sort of outside intervention that has required or recommended the contact. A program may also be contacted by someone whose relationship involves repeated incidents of violence, but who honestly does not feel that a pattern of coercive control or resistance is present. Victims subject to repeated incidents of violence are much more likely to seek advocacy assistance or come to the attention of the criminal justice system.

Johnson & Leone (2005) describe this context as *situational couple violence* because it arises out of the dynamics of particular conflicts in the relationship but does not involve an overall effort to coerce or entrap, or to resist such domination, the hallmarks of IPV with coercive control and resistive violence. The violence ranges from mild acts to homicide and from infrequent to regular acts, but without the presence of coercive control. Further, they indicated that persistent unresolved conflicts can escalate into violence, and that one or both partners may continue to use violence in that context.

Assessment Tip: It is important to identify appropriate services for victims of chronic situational violence. They are likely to benefit from the services useful to victims of IPV with coercive control, such as support groups or emergency shelter. Restraining orders can provide separation from the conflict, and criminal justice intervention may be necessary to confront the perpetrator about the use of violence, especially if it is ongoing, and provide motivation to change. As reported by Eckhardt, Holtsworth-Munroe, Norlande, Sibley, (2009), men in this category were more likely to complete a batterer's intervention program than those in the coercive control category and had lower rates of re-offense. Given this finding, mandating these abusers to intervention programs may provide more effective interventions. If, over time, the victim decides to remain in the relationship and the perpetrator has ceased to use violence, intimidation, or threats, resources such as individual or couples counseling may provide help in understanding and addressing the barriers to resolution of ongoing conflicts.

It is important to talk with the victim about any fears regarding the possibility of retribution or punishment resulting from discussions in counseling sessions. Many partners desire to stay together and will choose to address the violence and conflict in the relationship through couples counseling. Even if it appears that the violence in a particular relationship is not IPV with coercive control, it is still important to determine whether a victim feels safe enough to attend counseling with the partner. If this is an issue, individual counseling or other options could be pursued by the partners separately until this is no longer a concern.

IPV related to Mental Illness, Substance Abuse, or Brain Injury

Although a small number of people living with mental illness commit violent acts, research indicates that links between mental illness and violence, including IPV, are mediated by many other factors, such as substance abuse, environmental stressors, and history of violence (Elbogen & Johnson, 2009). One review article on research over the past 15 years identified the risk factors for psychiatric violence as: history of violence; noncompliance with pharmacological and outpatient treatment; substance abuse; violent ideation or fantasies; acute persecutory delusions with negative affect; and brain lesions (Joyal, Dubreucq, Gendron, & Millaud, 2007). Recently, evidence has been mounting that co-occurring substance abuse in people with psychiatric disorders is a major factor increasing the risk of committing violence (Dubovsky, 2011). However, how these factors interact or are mitigated by protective factors is still unknown.

Studies show that certain drugs, such as methamphetamines, cocaine, and alcohol can affect brain chemistry in ways that result in aggression and violence. Again, studies find that the relationship between substance abuse and violence is complex and moderated by factors in the individual and the environment (Boles & Miotto, 2003). Effective interventions in cases where an abuser also presents with substance and/or alcohol abuse will address those conditions separate from the abuse. Traumatic brain injury (TBI) is also associated with increased risk of violence and aggression. However, the nature of the violence, the specific details of the TBI, and other environmental factors are key to assessing any causal link between TBI and a violent incident (Toteno, Jorge, & Robinson, 2003).

***Assessment Tip:** More commonly, mental illness, substance abuse, or brain injuries are co-occurring conditions in perpetrators of IPV that occur in all contexts. This emphasizes the need for careful assessment to determine if these conditions are part of the context in which the IPV is embedded so that interventions can effectively address both the factors related to the increased risk of violence associated with the co-occurring conditions and the conditions themselves.

Combat Experience, IPV, and Context

Due to the increased numbers of military service members who deployed to a combat zone for more than a decade, the importance of exploring whether IPV is associated with trauma or brain injury has gained attention. Exposure to combat subjects military personnel to extreme levels of stress in conditions that are life threatening. In many cases, military personnel and veterans experience some level of post-traumatic stress disorder (PTSD), and in some cases, the resulting PTSD is associated with aggression or violent behavior after return from a combat zone. Likewise, serious brain injuries inflicted in a combat zone, particularly by explosions and blasts, can be the cause of atypical violent behavior.

Experience with IPV in the military over the past decades demonstrates that some military personnel were perpetrators of IPV with coercive control or IPV without coercive control prior to their combat exposure. Therefore, in each case a careful assessment needs to be done to determine if the PTSD or TBI is associated with the onset of IPV or if it is a co-occurring condition. It is also important to emphasize that IPV involving military personnel and veterans may occur in any of the contexts described above.

Assessing Risk and Danger

Risk assessment is viewed as a process that must include a range of information that is updated regularly. An essential consideration is the victim's perception of her/his situation and the development of responses that support decision-making and safety. Victims also tend to anticipate what they may or may not do in response to the violence and how that might affect the outcomes - thus improving the prediction (Gondolf E. W., The Future of Batterer Programs: Reassessing Evidence-Based Practice, 2012). Victims are fairly good predictors of their own risk (better than chance), yet not accurate enough to depend upon as the sole assessment of risk. There is general consensus in research literature identifying risk factors that help predict continuing and escalating violence (Dutton & Kropp, 2000; Goodman, Dutton, Bennett, 2000; Kropp, 2008; Weisz, Tolman, & Saunders, 2000). Most risk factor lists include:

- A history of violent behavior toward family members (including children), acquaintances, and strangers
- A history of physical, sexual, or emotional abuse toward intimate partners (there is a strong link between threat of bodily injury and actual bodily injury, suggesting that abuser threats should be taken seriously (Tjaden & Thoennes, 2000))
- Use of or threats with a weapon
- Threats of suicide
- Estrangement, recent separation, or divorce
- Use of drugs or alcohol daily
- Antisocial attitudes and behaviors and affiliation with antisocial peers
- Presence of other life stressors, including employment/financial problems or recent loss
- A history of being a witness or victim of family violence in childhood

- Evidence of mental health problems and/or a personality disorder (i.e., antisocial, dependent, borderline traits)
- Resistance to change and lack of motivation for treatment
- Attitudes that support violence toward women
  (Hotaling & Sugarman, 1986; Kropp & Hart, 2000; Pence & Lizdas, 1998; Roehl & Guertin, 2000; Sonkin 1997; Straus, 1992)

Assessing for potential lethal abuse is very difficult. Partly because the rates of domestic homicide are relatively low compared to the rates for domestic assault, and many violent men in batterer programs have the same characteristics associated with men who murdered their partners. It is less difficult to distinguish extremely violent men from the population as a whole than it is to distinguish them from other men who tend to be violent (Gondolf E. W., 2012). Understanding known risk factors has helped in development of risk and danger assessment instruments that have been shown to predict the likelihood that a victim of IPV will be re-assaulted in the short-term and to identify the potential for lethal IPV in a given relationship. The most accurate predictions of re-assault were obtained by combining the victim's perception of risk with the use of the Campbell Danger Assessment (DA) (Heckert & Gondolf, 2004; Roehl, O'Sullivan, Webster, & Campbell, 2005).

The DA was developed using known risk markers for lethal violence and is meant solely for use with the victim. Studies have also shown the DA to be predictive of re-assault in the short-term (Goodman, Dutton, & Bennett, 2000; Weisz, Tolman, & Saunders, 2000). In addition to the risk markers listed above, the DA includes:

- Access to gun in the house
- Choking or attempted choking
- Survivor beaten during pregnancy
- Forced sex
- Stepchild in the home
- Partner is obsessively jealous and controlling
- Partner is unemployed

***Assessment Tip:** Using an assessment tool should never take the place of having respectful conversations about risk and danger with victims. There are certainly some victims who perceive that the danger of their situation is vastly different from the result of the assessment tool. Victims know their partners; they live with their own fear, and most are already using strategies to minimize the violence to themselves and their children. The goal of the risk review conversation is to identify the possibility of life-threatening violence and serious risk to the victim and children (Davies, 2008) and strategize to prevent future violence. Risk assessment can be best used to aid a victim's safety planning, decision-making and accessing services. It can help to reinforce and broaden victims' perceptions, rather than imposing decisions on their situations from the outside (Cattaneo & Goodman, 2009).

IPV Risk and Danger Related to Combat Exposure

Many of the risk factors for IPV are the same in both the military and civilian populations. However, there are some additional considerations for the military population, which is a generally a young population with half under 25 years of age (Department of Defense, 2015, p. iv). Constant mobility and geographic separation isolate victims by sometimes creating physical distance from family

and familiar support systems. In addition, deployments and reintegration create unique stresses for military families, as does combat exposure.

Research has shown a link between combat and trauma and increased violence at home, often directed at partners (MacManus, et al., 2012). If the partner has deployed to a combat zone, a victim may wonder if the partner's violence is a symptom of combat-related conditions such as PTSD or other co-occurring conditions like depression or substance abuse. It is important to take this seriously and further inquire about the history of violence in the relationship.

- Was the partner violent and/or controlling prior to combat exposure? Is the violence worse now, increasing in severity or frequency?
- Has the victim noticed other behavior changes, such as depression, irritability, increased use of alcohol or drugs?
- Has the partner talked about or threatened suicide?
- If the partner has only become abusive since returning from the combat zone, and the victim feels that behavior is significantly different since returning, these behaviors may be combat related.

***Assessment Tip:** If the violent or "scary" behaviors are "new," the partner should be encouraged to have an assessment for PTSD and other combat-related issues. If there is a prior history of abusive and/or controlling behavior, and/or the violence is escalating or seems "different," there may be combat-related issues in addition to the IPV behaviors. In this situation, the partner should be encouraged to have an assessment for PTSD and other combat-related issues. In the case of criminal justice system involvement, a thorough assessment of the abusive partner's history should be required, as it can help uncover the context, the degree to which it is PTSD, TBI, or combat-related, and what types of interventions are most appropriate.

Evidence of PTSD, depression, and suicidal talk is a dangerous combination for service members and veterans and should raise a red flag for responders when IPV is accompanied by these co-occurring conditions. Always inquire about access to guns and other lethal weapons, another serious risk marker. Additionally, any condition that involves impulsivity such as TBI and/or alcohol/drug use or abuse increases risk of serious injury or death for IPV victims. Therefore, it is important to talk with victims about short- and long-term safety options and strategies.

THE INTERSECTION OF INTIMATE PARTNER VIOLENCE AND CO-OCCURRING COMBAT-RELATED CONDITIONS

Magnitude of the Problem

The United States was at war in Afghanistan and Iraq for over 10 years. Over 2.7 million people served in one or both of these war zones, including an unprecedented number of Reserve and National Guard personnel. Many experienced multiple deployments, extended tours, and decreased breaks from combat.

Most people returning from war zones will have stress reactions and will need to readjust to being home. This can be especially intense during the first months after returning. It is important to understand these stress reactions and their relationship to IPV to conduct adequate risk assessment and safety planning. This understanding is also important to provide effective information and referrals to victims whose partners have been exposed to the trauma of combat and are exhibiting violent or abusive behavior. These common stress reactions are a normal part of readjustment. Anger, anxiety, fear, aggression, and/or withdrawal are common war-zone stress reactions. Even minor incidents can lead to over reactions.

Stress reactions and problems that last for months can affect relationships, work, and overall well-being if not addressed. A person may be coping with stress by drinking, taking drugs, withdrawing, isolating, and/or he/she may be having sleep problems, bad dreams or nightmares, or sudden emotional outbursts. He/she may also startle easily and have problems trusting others. It is important to emphasize that while most returning military personnel have readjustment and stress issues, **most military personnel and veterans who deployed to war zones do not become abusive to their partners and/or families and most eventually readjust successfully to life back home** (National Center for PTSD, U.S. Department of Veterans Affairs, 2014). However, if these problems persist, it is important for the service member or veteran to be assessed for PTSD, TBI, and depression (Carey, 2010; National Center for PTSD, U.S. Department of Veterans Affairs, 2014).

In its landmark 2008 study, "Invisible Wounds of War," the RAND Corporation estimated up to one-third of those previously in Iraq and Afghanistan were suffering from PTSD, TBI, and/or major depression, but only half reported or sought help (RAND Center for Military Health Policy Research, 2008). Since the war began in October 2001, there have been periodic reports about substance abuse, depression, IPV, homicide, suicide, homelessness, and other violent crime among traumatized veterans of Afghanistan and Iraq. At times, high unemployment in a bad economy exacerbated the problems (Carey, 2010).

The most recent report on justice-involved veterans, the Department of Justice's Bureau of Justice Statistics (BJS) *Veterans in Jail and Prison*, found a greater percentage of veterans (64%) than nonveterans (48%) were sentenced for violent offenses. Unfortunately, neither this report nor previous versions published by the BJS provide data for veterans and offenses involving IPV (Bronson, J. Carson, A, Noonan, M. E., & Berzofsky, 2015). There have been snapshots of what is transpiring in some individual communities. Travis County (Austin), Texas' *Veterans in Jail Report* corroborated anecdotal observations that IPV and related offenses may constitute up to one-quarter of all veteran offenders entering the justice system (Fairweather, Gambill, & Tinney, 2010).

Overview of Co-occurring Conditions

The term co-occurring disorders refers to at least one substance use and mental disorder (Atkins, 2014). This document includes IPV as another issue in this complex matrix. The term comorbidity in medicine refers to one or more additional diseases or disorders that are simultaneous, and may overlap with another condition increasing the overall complexity of the patient's status. Co-occurring disorders may also overlap, manifesting in similar symptoms and behaviors and increasing the complexity of the situation and interventions. A change in the status of one condition may cause a cascade that impacts the status of the other conditions or disorders, either for better or for worse. For example, a person who has been using substances to cope with PTSD symptoms may experience worsening PTSD symptoms for a period when they become clean and sober. Or, as another example from clinical practice, an IPV offender who enters offender intervention with depression and feeling suicidal may experience complete resolution of depressive symptoms upon completion of offender intervention.

For this reason, it is best to think of the co-occurring conditions addressed herein as a complex matrix of symptoms and behaviors that are interconnected. The symptoms and behaviors associated with the co-occurring conditions may be in a state of flux, changing as the service member or veteran seeks services and engages (or drops out) of treatment. All the co-occurring disorders addressed in this document are common for military veterans, and all are risk factors associated with violent behaviors (Elbogen, et al., 2010).

Post-traumatic Stress Disorder

PTSD is a major mental health diagnosis based on eight criteria (American Psychiatric Association, 2013). Responses to traumatic or stressful events can be quite variable and can include psychological manifestations of fear/anxiety, anhedonia/dysphoria, anger/aggression, or dissociative symptoms. Most people with psychological distress after a traumatic event/s will have some combination of these symptoms. Service members, who have been deployed to a war zone, and who have been exposed to an extremely stressful event that involves the criteria identified in part A below, may develop symptoms of PTSD. The extremely stressful event (referred to as a "trauma") may be a combat experience/s, something else related to deployment, or a traumatic experience not related to deployment, combat, or even military service.

A) A person directly experienced, witnessed as it occurred to someone else, learned about a traumatic event/s occurring to a close family member or friend, or experienced repeated or extreme exposure to aversive details of the traumatic event/s (American Psychiatric Association, 2013, p. 271) **and** is experiencing one or more of the following symptoms:

B) Re-experiencing
- Intrusive distressing memories
    - Recurrent, involuntary, intrusive distressing memories
    - Distressful dreams/nightmares
    - Acting or feeling as if the traumatic event were recurring (e.g., dissociative flashbacks)
    - Intense psychological distress when exposed to internal or external cues (triggers) that resemble an aspect of the traumatic event/s
    - A physical reaction when exposed to cues (triggers) that resemble an aspect of the traumatic event/s

C) Avoidance
   - Efforts to avoid thoughts, etc. of the event/s
   - Efforts to avoid external reminders such as activities, places, reminders that arouse memories

D) Negative alterations in cognitions and mood associated with the traumatic event/s
   - Inability to recall an important part of the traumatic event/s
   - Persistent and exaggerated negative beliefs and expectations about oneself, others, or the world
   - Persistent, distorted cognitions about the cause or consequences of the traumatic event/s (blaming self or others)
   - Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
   - Feelings of detachment or estrangement from others
   - Persistent inability to experience positive emotions

E) Marked alterations in arousal
   - Sleep disturbance
   - Irritability or outbursts of anger (with little or no provocation) expressed as verbal or physical aggression toward people or objects
   - Reckless or self-destructive
   - Difficulty concentrating
   - Hypervigilance (being constantly tense and on guard)
   - Startles easily

To fully meet the criteria for this diagnosis, the person must have experienced some of these symptoms for at least one month (criteria F), have clinically significant distress or impairment in social/occupational/important areas of functioning (criteria G), and these are not attributable to the physiological effects of a substance (criteria H). A person may also experience dissociative symptoms, such as feeling detached from or as an outside observer to themselves, or feel like they are in an unreal, dreamlike state (American Psychiatric Association, 2013, pp. 271-272).

Few people experience every symptom listed, however, if a person has a range of symptoms from each category as a result of a traumatic experience, he/she meets the criteria for the diagnosis. Some individuals will have some of these symptoms but not enough to "fully" meet the criteria for the diagnosis. Other individuals will have some of these symptoms for a period of time after returning from a deployment, but they resolve within a few months. Others may not experience any (or very few) symptoms after deployment but have trouble later on in life (often associated with some stressful event e.g., major illness, divorce, loss of a job, retirement, etc.) and begin to experience the full range of PTSD symptoms. Estimates vary from 18% of veterans with deployments to Iraq and Afghanistan to as high as 35% have PTSD. PTSD is an enduring consequence of warzone participation, with close to 25% of Army service members and veterans of Iraq meeting PTSD criteria at a long-term follow-up (7.2 – 8.5 years) (Vasterling, et al., 2016).

A relationship between PTSD and IPV perpetration has been found consistently in research studies (Gerlock, Szarka, Cox, & Harel, 2016; Gerlock, 2004; Orcutt, King, & King, 2003; Sayers, Farrow,

Ross, & Oslin, 2009). Certain PTSD symptoms **may or may not** result in IPV perpetration. Each of the symptom criteria below have elements identified where the two may intersect. The challenge here is to determine if these behaviors are stand-alone PTSD symptoms or if the behaviors are part of a pattern of coercive control and assaultive behaviors.

Re-experiencing:

- **Nightmares** are very common for service members and veterans who have developed PTSD secondary to war zone deployment/s. It is not uncommon to strangle or hit a partner in response to a nightmare. In couples where there is no pattern of coercive control or assaultive behaviors, this is a stand-alone PTSD symptom and not an IPV perpetration tactic. These couples work together to put safety first, often sleeping separately until the nightmares settle down or are quieted through PTSD-specific treatment. If the assault on the partner occurs within the context of other coercive or assaultive behaviors, it is probably IPV.

  Case Example: The wife of an Army veteran reports that her husband strangled her while she was sleeping. She thought it was associated with a nightmare. However, he also started to act differently towards her during the day. He called her terrible names while yelling at her. He strangled her again the other night and when she started to scream at him to stop, he was already awake. This time it was different. She thought that he was "practicing" strangling her.

  In this example, the strangulation during a "nightmare" fits into a larger pattern and is an IPV perpetration tactic. However, he is also having nightmares related to his war zone deployment. He is experiencing PTSD symptoms and perpetrating IPV.

- A full **flashback** (fully re-experiencing a traumatic event, as if it were happening all over again) is not as common as nightmares. However, they are equally distressing when they occur. A flashback may be triggered by an external cue (a smell, sight, sound, temperature, etc.). In the flashback, the person may respond aggressively to what he/she believes is happening. This aggression is not specific to any one person, but anyone standing nearby may inadvertently be assaulted. When this occurs in a couple's relationship, where there is no other pattern of coercive control or assaultive behaviors, it is a stand-alone PTSD symptom and not an IPV perpetration tactic.

Avoidance:

- It is common for people with PTSD symptoms to withdraw from family and friends and avoid engaging in activities they once enjoyed. Avoiding intimacy, not wanting to talk, and withdrawing from family all have a significant impact on spouse/partners, family, and friends. For example, the person with PTSD may no longer want to attend church or go to gatherings or other activities where there are crowds of people. When this person imposes that isolation on him/herself without imposing it on his/her partner or family (without restricting the activity of the partner), it is not IPV. When there is no other pattern of coercive behavior or physical assaults, then it is a stand-alone PTSD symptom and not an IPV perpetration tactic.

- However, trying to isolate a partner from the support of family and friends is a tactic of IPV perpetrators.

  Case example: A Navy veteran's wife reports that when her husband first got back from Iraq, he didn't want to leave the house. He wasn't comfortable in crowds. For a while he went to church and sat in the last row but then stopped going all together. This was hard on her. He didn't want to go to family get-togethers. He stopped going to movies and didn't want her friends to come over. They are spending less and less time together.

  In this example, the veteran describes feeling uncomfortable with going out, but he socially isolates himself while encouraging his wife to go out without him. He does not impose his social isolation on her. This is an example of a PTSD avoidance symptom.

  Compare this to another example:

  Case example: A woman reports that she has been dating her boyfriend, who is in the National Guard, for about four years. He has always been jealous and has accused her of sneaking around and seeing other men. This got worse when he came back from Iraq. Now, when she gets ready to spend an evening with her girlfriends, he starts to pick on her. He questions her about everything: where she is going, who she is seeing; why she is getting fixed up just to go out with her girlfriends. He follows her around the house while she is getting dressed. He tells her he does not want her to go. There are more questions when she gets home. Therefore, it's just easier for her to stay home with him and not go out.

  In this second example, the boyfriend is making it very difficult for her to go out with friends and family and is accusing her of seeing someone. He not only discourages her from going out; he also makes it very difficult for her. It is unclear if he is also socially isolating himself. That would require more assessment. This is an example of an IPV tactic of using isolation to cut the victim off from her support system.

<u>Increased arousal</u>:

- The link between increased arousal and IPV perpetration has received the greatest research focus (Taft, Vogt, Marshall, Panuzio, & Niles, 2007; Taft, et al., 2009). People with PTSD may be super aware of their surroundings and those around them, or **hypervigilant**. They are particularly alert to any potential sign of danger or may think there is danger when no true threat exists. They may easily startle with a loud noise or sudden, unexpected movement and may be often irritable and easily angered. Small, daily stressors may upset or anger them. Once again, while family members are most often witness to these events and are greatly impacted by them, they are **not singled out** as targets. If no other pattern of coercive control or assaultive behavior exists, then it is a stand-alone PTSD symptom.

- When there is IPV, behaviors such as stalking or monitoring a partner's coming and going and other behaviors may be confused with hypervigilance.

Case example: An Afghanistan veteran's wife reports that he calls her frequently all-day long. It is not unusual for him to call over 100 times a day. If she does not answer the phone or turns it off, there is a big fight waiting at home. He accompanies her everywhere and will not let her visit her friends or family. She finally cut off contact with her family and friends because it always caused a fight.

In this example, these tactics are used in the context of a larger pattern of coercive control in a relationship where there had also been physical violence.

- If **anger** is consistently directed at the partner, or expressed as a pattern of intimidation or threats, IPV is likely present, as in these examples.

  Case example: A Marine reported that he had weapons of all types placed around the house. Whenever he argued with his wife, he told her that if she kept arguing with him and saying things he did not like, he would use his weapons on her, and she would come up missing. He said he would kill her.

  Case example: The wife of an airman tells you that her husband has an anger problem. She reports that little things escalate quickly, and he flies into a rage. She describes this behavior as becoming worse since his return from Iraq. The anger alone may be a PTSD symptom; however, with further questioning she reports that he has been physically assaultive to her. As recently as a week ago, he threw her up against the wall in one of these "fits of rage."

- **Startle response** is another PTSD symptom that may occur along with IPV perpetration. When someone with PTSD is startled, he/she may strike out as a reflexive reaction. It is important to determine if there is a larger pattern of coercive control also happening in the relationship.

  Case example: A Marine recently back from a tour in Afghanistan reports that he did not hear his wife come home. He was on the computer, and she came up behind him and leaned forward to see what he was working on. He was startled and struck her in the face, knocking her over.

  This is an example that police and health care professionals alike may consider IPV and is why it is important to ask more questions to determine if there is a pattern of coercive control and other assaultive behaviors. In this example, the Marine has been back for a month. He describes other readjustment concerns such as withdrawing from family and friends. There is no other pattern of coercive control or assaults, as verified by his wife. He does not describe a full range of PTSD symptoms, but he is having adjustment problems.

***Assessment Tip:** Recognizing and understanding how IPV and PTSD may intersect is important, as is understanding how they differ. This understanding drives the actions taken, resources provided, and recommendations made.

Other Combat-Related Conditions

Traumatic Brain Injury

Service members have been experiencing TBIs as long as there have been wars and conflicts. A TBI is a disruption of brain function and disturbance of consciousness caused by an external injury to the head. Service members who have been deployed to a war zone may have experienced brain injury secondary to blast injuries, shrapnel, or bullets above the shoulders or falls or other injuries where they have experienced a blow to the head. A brain injury may result in a brief loss of consciousness, or altered consciousness (e.g., confusion or feeling as if things are moving in slow motion), a mild TBI, or other more severe symptoms that impair emotional and behavioral functioning and thinking processes (cognitive functioning).

People with a TBI may have the following symptoms (U.S. Department of Veterans Affairs, n.d.; Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) and the Defense and Veterans Brain Injury Center (DVBIC, 2010):

- Cognitive functioning: Loss of consciousness, working memory problems, impaired attention, slowed thinking and reasoning processing, and communication problems
- Emotional functioning: Depression, anxiety, irritability/rage, and mood swings
- Behavioral functioning: Agitation, aggression, acting on impulse, not caring about things, and sleep disturbance
- Physical functioning: Headaches, pain, visual problems, dizziness/vertigo, and seizures

Most TBIs are mild with symptoms occurring during the first week after the injury with resolution of symptoms within a few weeks to months. Most people who experience a mild TBI report full recovery within the first six to 12 months, but individuals with moderate to severe TBIs may continue to have symptoms beyond a year.

Exhibiting aggressive behavior after a moderate to severe TBI is common and generally seen within the first year after the injury. However, this aggression may also be associated with a major depression and pre-injury substance abuse (Carlson, et al., 2011; Hoge, et al., 2008). TBI can also cause subtle changes in how a person interacts with other people. The person may have difficulty reading and interpreting social cues. A harmless remark may be misinterpreted and responded to with aggression. As with PTSD, it may be difficult to distinguish a TBI-related symptom or behavior from an IPV perpetration tactic. The challenge is to determine if these behaviors are stand-alone symptoms or if the behaviors are part of a pattern of coercive control and assaultive behaviors.

> **Case example**: The wife of a Vietnam veteran reports that her husband was "blown up" in Vietnam. He is forgetful, and she understands this is related to his TBI. He is also easily angered, and that too makes sense to her because she understands it is related to his brain injury. However, when she takes a weekend to work the arts and crafts fairs, he calls her all-day long. He calls her names and accuses her of having affairs and sleeping with other men.
>
> In this example, she correctly identifies the general problems with memory and anger that can be associated with a serious TBI. She also correctly points out how a TBI does

not seem to explain his ongoing name calling, accusations, and constant monitoring of her through the phone calls. These are examples of IPV perpetration tactics.

While family members are more likely to witness TBI symptoms and are more impacted by them, the symptoms themselves are **not specifically targeted** at a partner or family member. When these symptoms are not part of a larger pattern of assaultive and coercive behavior, it is a TBI stand-alone symptom and not an IPV perpetration tactic. However, TBI can compound IPV perpetration by increasing the frequency and intensity of the IPV and escalating the risk to victims. The risk to victims also increases when abusive behaviors are incorrectly classified as TBI, and IPV is not identified and responded to appropriately.

Interventions specifically targeting TBI may improve management of the anger symptoms (Hart, et al., 2017) but will not change the IPV behaviors. The autonomy of victims, who are also caregivers for the service member/veteran with TBI, may be further reduced as the responsibility for the day-to-day care of the veteran (making and driving the veteran to appointments, managing medications, being responsible for remembering and keeping track of things for the veteran and the whole family, etc.) falls on them. Thus, it becomes more difficult to leave the violent partner.

***Assessment Tip:** Anger and impulsivity associated with a TBI requires specialized treatment. Individuals may have a TBI and be IPV perpetrators. Persistent angry and threatening behaviors that last beyond the time expected for TBI symptoms to resolve are more likely IPV perpetration tactics.

Substance Use Disorder (SUD)

SUD reflects a range of substance-related and addictive disorders that vary along a continuum from intoxication, withdrawal, abuse, and dependence with a range of substances, including alcohol, cocaine, marijuana, and more (American Psychiatric Association, 2013). With SUDs there are cognitive, behavioral and physiological symptoms that persist when the individual continues to use despite significant substance-related problems.

It is not uncommon for service members and veterans to increase their alcohol and drug use during and after a war zone deployment. Drugs and alcohol may be used to relax, to forget about the war zone, or to sleep. They may also be used to avoid thinking about their war zone experiences. In one study, service members with deployments to Iraq and Afghanistan, and who had combat exposure, had increased alcohol problems, binge drinking, and heavy drinking post-deployment (Jacobson, et al., 2008). Among Army service members, binge drinking was found to be more common among those who were younger, exposed to combat, recently returned from combat, and having marital problems (Lande, Marin, Chang, & Lande, 2008). In addition, among Army service members, 25% of soldier IPV offenders were using substances at the time of the offense. Alcohol use in particular was more likely associated with physical (as opposed to emotional) abuse, and increased abuse severity. While illicit substances were also identified, some researchers believed they were less prevalent than alcohol because of routine drug testing and because illicit drug use could result in discharge from the Army (Martin, et al., 2010).

Military veterans with co-occurring PTSD and SUD were found to have greater psychological problems with worse outcomes, and greater medical, legal, and social problems. They also had higher levels of aggression and IPV (Veterans Health Administration, Office of Public Health and Environmental Hazards, 2009). In a sample of veterans in treatment for PTSD, current and past drug use, in addition to the number and frequency of drugs used, were all significantly associated with physical assaults on their intimate partners. Binge drinking was also significantly associated with current physical violence (Gerlock A. A., 2011).

In the short term, alcohol and some drugs are effective in quieting PTSD symptoms. However, this short-term benefit is quickly lost as the interpersonal and health costs mount with continued use. Not only might symptom reduction decrease with continued alcohol and drug use, but a sleep disorder may worsen, known as an alcohol rebound effect (Roehrs & Roth, 2001). There may be significant impairment in other important areas of a person's life. Other points to consider:

- Substance use can cause both physical symptoms and impairment in cognitive functioning.
- According to McCarroll, Fan & Bell (2009), there is a relationship between alcohol and both IPV perpetration and victimization.
- The question of whether drinking causes IPV perpetration has been controversial. However, it is well accepted that alcohol abuse, particularly binge drinking, is associated with both increased frequency and severity of IPV (Bell, Harford, McCarroll, & Senier, 2004; Fals-Stewart, 2003; Fals-Stewart, Golden, & Schumacher, 2003; Savarese, Suvak, King, & King, 2001).
- IPV is often identified as a co-occurring problem for people seeking alcohol and drug treatment (Savarese, Suvak, King, & King, 2001).
- Rates of both IPV victimization and perpetration are higher for treatment-seeking individuals than community samples. For this reason, substance abuse treatment programs are an important point of entry into the mental health system and a critical element in the coordinated community response to IPV (Chase, O'Farrell, Murphy, Fals-Stewart, & Murphy, 2003; Chermack, Fuller, & Blow, 2000; Gondolf & Foster, 1991; Stith, Crossman, & Bischof, 1991.

While people with SUD, without co-occurring IPV, can present with anger/irritability and impulsive behavior (especially in withdrawal and intoxication), the behaviors are **not specifically targeted** towards an intimate partner or family members. Nevertheless, these behaviors have a significant impact on an intimate partner and family members.

***Assessment Tip:** There is additional risk to IPV victims when all behaviors are attributed to a substance use disorder, and IPV is not identified and addressed. Interventions targeting substance abuse will not change the IPV perpetration behaviors or the attitudes and beliefs that support those behaviors. For this reason, treatment for both SUD and IPV perpetration are important, but very different; and a substance use/abuse assessment is usually required prior to entering an IPV offender intervention program. If identified, both types of treatment are recommended. (It is important to note that some jurisdictions and offender intervention programs may require a period of sobriety prior to entering a program.)

Case example: The girlfriend of a Marine reports that her boyfriend has been drinking a lot more since he got back from Afghanistan. He says it helps him relax and get to sleep. She says they used to drink together but sometimes he would get mean when he drank. She says his drinking starts earlier in the day. She tries to stay very quiet and not upset him. She hopes he will just go to sleep. If he gets upset, he starts to yell and break things. She gets really scared of him.

In this example, further assessment would be needed to better determine if there is IPV and the extent of his drinking problem. However, it does appear that he has problem drinking and describes having difficulty sleeping and relaxing—which may imply PTSD symptoms. She also describes feeling afraid. She describes him as getting mean and provides examples of threatening behaviors (yelling and breaking things). Alcohol misuse, IPV perpetration, and PTSD may all be present.

Depression

Depression is common among veterans and service members and frequently co-occurs with PTSD and SUD (Institute of Medicine of the National Academies, 2008; Seal et al., 2009). Nearly 20% of veterans returning from deployments to Iraq and Afghanistan reported symptoms of depression, with findings showing a higher rate when both PTSD and depression are co-occurring (RAND Center for Military Health Policy Research, 2008). According to the National Survey on Drug Use and Health Report from November 6, 2008, (Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services) an estimated 9.3% of veterans aged 21 to 39 experienced at least one major depressive episode in the past year and more than half received treatment for depression. Over half had severe impairment in at least one of four areas (to include close relationships with others and social life). Untreated mental health problems can result in long-term negative consequences for veterans, their families, and communities.

A major depression is characterized by a period of at least two weeks during which there is either a depressed mood or the loss of interest or pleasure in nearly all activities. People with depression experience the following symptoms (American Psychiatric Association, 2013, pp. 160-161):

- Depressed mood most of the day, nearly every day
- Diminished interest or pleasure in all or almost all activities, nearly every day
- Significant weight change (weight loss when not dieting or weight gain)
- Sleep disturbance (insomnia or hypersomnia nearly every day)
- Slowed response or agitated behavior
- Fatigue or loss of energy
- Feeling worthless or excessive inappropriate feelings of guilt
- Impaired concentration
- Recurrent thoughts of death or killing themselves

While not everyone experiences every symptom listed, experiencing five or more symptoms meets the diagnostic criteria for a major depressive disorder. According to the Veterans Administration, veterans from Iraq and Afghanistan with major depression and receiving VA services had a risk of suicide nine times greater than those without major depression (Veterans Health Administration, Office of Public Health and Environmental Hazards, 2009). Wisco and colleagues (Wisco, et al., 2014) found that current depressive symptoms, PTSD, and a history of a prior brain injury were all significantly associated with current suicidal thinking.

Table 1 highlights how depression and PTSD have symptoms that overlap:

Depression	PTSD
A person may have a lack of interest and stop participating in activities once enjoyed.	A person will avoid participating in activities in order not to trigger the PTSD symptoms.
A person may have trouble getting to sleep and staying asleep or may awaken early and be unable to get back to sleep.	A person will have the same type of disturbed sleep compounded by nightmares or night terrors. This results in considerable fatigue and loss of energy during the day.
A person may have thoughts of death or make plans to kill him/herself (sometimes following through with the plan).	A person may wish to be dead because of survival guilt, feeling guilty that he/she survived when friends and comrades did not. He/she may feel as if something bad is about to happen and believe that there is not long to live.

When a service member or veteran is perpetrating IPV, it is critical that he/she be referred for a thorough assessment for depression and suicidal thinking. One factor associated with suicide and suicide attempts is a known failure in a spousal or intimate relationship. According to the Department of Defense (DoD) Suicide Event Report (2013), nearly 90% of service members who completed suicide had a failed intimate relationship within 90 days of the suicide (Smolenski, et al., 2015, p. 55). Other important considerations about depression when IPV is also present:

- The consequences of IPV perpetration are many. Perpetrators of IPV have identified depression secondary to their perpetration of violence (Gerlock A. A., 1999).
- Depression interferes with focus and concentration, which could interfere with a perpetrator's ability to respond adequately to offender intervention and other types of treatment.
- When all perpetrator behaviors are attributed to depression and IPV is not identified and addressed, the link between suicidal thinking/intent and potential IPV homicide may be missed, thus increasing risk to victims.
- Depression, with hopelessness and a "nothing more to lose" mental attitude, along with suicidal thinking, may increase the potential risk for IPV-related homicide, especially if the IPV perpetrator is also jealous of and dependent on the victim (Campbell J. C., 1992).

Case example: The wife of an Army reservist tells you that her husband has been depressed since he got back from his deployment to Afghanistan. They have been arguing more. He has threatened to kill himself, but she thinks he does it just to shut her up.

In this example, it is important to gather more information about the nature of the arguments. Is he making threats to hurt her as well? Has he ever physically or sexually assaulted her? It is also important to determine if there is a pattern of coercive and threatening behaviors. She believes that the suicide threat is a manipulation, but such threats must be taken seriously because of the potential risk of injury or death to her or him, or both.

***Assessment Tip:** It is extremely important to identify depression when IPV perpetration is present. Treatment for depression will include an assessment for the symptoms of depression, along with any thoughts of self-harm. Additionally, treatment for depression often includes antidepressant medications and/or psychotherapy. While treatment for depression includes an assessment for suicidal thinking and self-harm, it does not necessarily include an assessment for thoughts of harming others. Without an IPV assessment as well, the critical link between homicide and suicide will be missed. The risk of homicide/suicide when IPV perpetration is present may persist despite the treatment for depression; thus, specialized treatment for both depression and IPV is critical. This is discussed in more detail in the next two sections of this document.

Suicide

The risk of suicide for service members returning from tours in Iraq and Afghanistan has received a great deal of attention in general and focused intervention from both DoD and the VA. Both the rates of mental health disorders (e.g., depression, PTSD, anxiety disorders, personality and psychotic disorders, and SUDs) and suicide among Army service members have been increasing since 2004. In 2008, between 25-50% of suicides were attributed to deployment to Iraq in 2003 (Bachynski, et al., 2012). When IPV is also present, suicidal thinking and intent takes on additional risk. Certain dynamics of IPV perpetration connect that risk to homicide. When it comes to killing him/herself, an IPV perpetrator who is highly jealous, suspicious, and possessive of his/her partner may be determined to kill the partner first and then kill him/herself. The relationship between suicide, IPV, and homicide has been reviewed in violent death reviews and domestic violence fatality reviews across the nation (National Domestic Violence Fatality Review Initiative, 2012). The 2008 Surveillance for Violent Deaths report identified the following data for military service members and veterans (Karch, Lubell, Friday, Patel, & Williams, 2008):

- Suicides by former and current military personnel comprised 20% of all suicides.
- Two hundred violent incidents involved homicide followed by the suicide of the suspect.
- Seventy-five percent of victims were female; 90% of suspects (suicide decedents) were male.
- Relationship problems or IPV were precipitating factors for many forms of violence.
- Nineteen percent of all homicides were precipitated by IPV.
- Fifty-two percent of all female homicides were precipitated by IPV compared with 9% of all male homicides.
- Thirty-two percent of all suicides were precipitated by a problem with an intimate partner.

The National Violent Death Reporting System (NVDRS) data for 2009 continued to show that relationship problems, "…particularly with an intimate partner, are common circumstances preceding suicides, homicides, and homicide-suicides in the 16 states studied" (Centers for Disease Control and Prevention, 2012, p. 13). These data paint a clear picture of the risk of homicide related to suicide and IPV.

Domestic violence focused fatality reviews have identified similar risks. For example, as a result of reviews that included a specific focus on homicide/suicide, Washington State Domestic Violence Fatality Reviews from 2000–2010 identified the importance of educating professionals about the risk of homicide where there is a suicidal abuser. During the period reviewed, close to 30% of the domestic fatalities were homicide – suicide. Many of the homicide perpetrators were depressed and/or suicidal (Fawcett, Starr, & Patel, 2008), and many had reported depression or another mental health concern (Fawcett, 2010).

Other fatality reviews report similar findings for the rate of homicide-suicide. For example, the Ontario Canada Domestic Violence Death Review Committee (Province of Ontario, Office of the Chief Coroner, 2012) reported close to half (47%) of the domestic violence deaths reviewed were homicide-suicide during the 2003-2011 review period. These findings clearly demonstrate the importance of determining if IPV is present when suicidal thought or intent is expressed.

Given the link between suicidal intent and homicide when IPV is present, suicidal intent is an obvious risk factor for lethal IPV. Domestic violence fatality reviews identify other risk factors that co-occur with IPV-related homicides. These include some of the combat-related co-occurring conditions previously addressed (mental health disorders and substance abuse/misuse). Any one of these co-occurring conditions may increase the frequency and severity of the IPV. When several of these conditions are present in addition to IPV perpetration, risk of lethal IPV must be considered.

A COMMUNITY-WIDE APPROACH TO SCREENING AND ASSESSMENT OF IPV PERPETRATION AND CO-OCCURRING CONDITIONS

Introduction

An effective response to IPV requires coordination among multiple community agencies and programs that come into contact with IPV victims and perpetrators. This is often referred to as a coordinated community response (CCR). A CCR is an interagency effort to change the climate of tolerance of IPV by institutionalizing practices and procedures that centralize victim safety and offender accountability in IPV cases.

Screening, assessment, and intervention occur at various points in a CCR.

Screening and Assessment

As noted in the previous section on combat and co-occurring conditions and IPV, military service members and veterans may have a range of physical and psychological problems. Some of these are brief and resolve quickly within a few months, but others may have a lasting impact on their lives and the lives of their family members. Service members and veterans are part of the larger community and will intersect with the full range of community systems, including schools, faith, leisure, health care, work, legal, etc. When problems arise, professionals need to understand what conditions may be unique to the military member or veteran, how to determine if those conditions exist, and what interventions are needed.

All co-occurring conditions can impact the frequency and severity of IPV and potentially increase lethality. Failure to recognize IPV when there are co-occurring conditions increases the risks to victims and perpetrators in several ways:

- If all behaviors are attributed to other co-occurring conditions, victims don't receive needed resource information and victim advocacy.
- Appropriate services are not recommended to the identified IPV perpetrator, who may not be held accountable for stopping the violence and abuse.
- If victims have the added role of caregiver for the perpetrator, their autonomy is further decreased if they feel required to remain in the relationship to take care of the service member or veteran.
- Both veterans and caregivers of veterans have identified the very act of caregiving as a trigger to abuse and violence (Gerlock, Grimesey, & Sayre, 2014).
- When IPV is present, suicidal intent could result in more than one death.

For these reasons, it is important that professionals across systems have some basic tools to screen for IPV and co-occurring conditions and understand their role in making a determination of the need for further assessment and intervention.

What is Screening?

A screening is a quick check to determine if something exists. In the case of blood pressure, it is a spot check to determine if someone has high blood pressure. In other settings, a screen may be a couple of questions that are routinely asked to determine if a certain problem exists. These questions are usually considered reliable in identifying a problem, either through research or by consensus of

professionals within a given setting. The type of questions, timing, and method of gathering the information will vary depending on the nature of the information needed and the setting in which it is gathered (Gerlock, Grimesey, Pisciotta, & Harel, 2011). In general, almost anyone can conduct a screen if they have information on the problem they are asking about. Questions should be asked in a private setting, verbatim, and in a non-judgmental manner. On the other hand, when IPV is present, the concern arises that a screen may inaccurately identify a victim who has used physical force in an attempt to contain the violence, as the predominant aggressor. In this case, a more thorough and nuanced assessment is needed. For example, in a study examining relationship behaviors in a clinical sample of male veterans and their wives and partners, 35% of the partners (as identified by both the veterans and their partners) used physical force in the relationship. However, with further questioning, it was determined that in almost all the events described, the women were engaging in resistive violence (Gerlock, Szarka, Cox, & Harel, 2016).

What is Assessment?

Once screening identifies an issue, an assessment may be needed to establish a diagnosis, or in non-medical settings further define the problem, and will guide the response. An assessment is a more in-depth and focused analysis and may include accessing multiple sources of information (e.g., medical, legal, and/or military records) in addition to obtaining new information through interviews and possibly tests. An assessment will help determine what risk factors are present and what to do next.

Separate assessments must be conducted as they deal with distinct, though often overlapping, issues. For example, a mental health assessment can provide a diagnosis of PTSD, depression, and other mental health disorders, but it generally does not identify IPV and distinguish tactics of coercion and control from mental health symptoms. IPV program staff, pretrial, probation and parole officers, mental health professionals, and others may conduct these assessments, however, rarely does one individual have expertise to assess for everything. It is important to identify who can conduct which assessments and, if necessary, make appropriate referrals or provide the necessary training to those who do assessments.

Factors that may affect the accuracy of the information obtained during an assessment include: inadequately trained staff (i.e., staff who are unfamiliar with the condition or situation for which they are assessing); time constraints; inadequate access of available collateral information (e.g., police reports, previous arrests or convictions, medical or mental health information, etc.); acute intoxication of either the victim or perpetrator (a period of abstinence with a reassessment may be needed); reluctance on the part of the victim or offender to provide information needed for the assessment; and reluctance on the part of the victim or offender to share information out of fear of negative consequences.

Key Players

Numerous individuals and agencies are involved in the process of screening and assessment at different points in which a veteran intersects with the criminal justice system.

- **911 dispatchers/responders** are often the first to get the call about a domestic disturbance. Dispatchers and responders play a key role in how cases enter the criminal justice system for resolution. At this point, the key task is to assess danger to any potential victim and provide as much useful information as possible to maximize the safety of the responding officers and that

of any victims. Critical information to obtain includes what is happening, if there are injuries/deaths, if firearms or other types of weapons were used and still available, who is on the phone and if they are safe, if others are present, and previous calls to the location, etc.

- **Patrol officers** enter a highly charged and potentially dangerous situation. They will be trying to de-escalate the situation and keep everybody safe. At the same time, they will be attempting to gather critical information needed to determine if a crime has been committed and by whom, and determine the dangerousness of the situation. The responding officers review the immediate needs of the parties, separate them, and interview each party to determine whether a crime has been committed. If there is probable cause that an assault has taken place, they will arrest the alleged offender, advise him/her of his/her rights, and take him/her to jail. The other officer will give information to the victim about advocacy and advise the shelter advocates so they can contact the victim. If both parties have used violence, officers will assess for self-defense, and if necessary predominant aggressor. The officers then write a report, even if there has been no arrest.

- **Police investigators/detectives** may also respond to the scene depending on the crime committed. They are most often involved in felony level cases but can be involved in misdemeanors as well. When a suspect has been arrested, investigators may conduct follow-up interviews with the victim and the suspect and obtain statements from witnesses to obtain additional information to build a case to support charging (or releasing) the suspect.

- **Correctional** officers (jail and prison) may become aware of mental health, medical, or safety issues through daily interaction with inmates. They are in a position where they can conduct basic screens and may suggest assessments. Further assessment can also be prompted by the inmate through communication with the institution medical staff.

- **Pretrial services, probation,** and **parole** have similar responsibilities at different points in the criminal justice process. Pretrial oversees individuals who are charged with crimes that have not yet been adjudicated by a court; probation (in some jurisdictions, known as **community supervision**) those who have been sentenced (whether to incarceration or not) and placed on formal supervision; and, parole those who have served a longer period of incarceration and have been released. Pretrial or probation, depending on the jurisdiction, often provide reports to the courts in order to recommend terms and conditions of sentences. Pretrial, probation and parole all monitor individuals to ensure compliance with all sentencing or release requirements (to include staying clean and sober) and maintaining law-abiding behavior. They are often in the position to determine if additional services/resources are needed to assist the offender in meeting those conditions or if any new issues arise. Pretrial, probation and parole can recommend revocation of release and can usually take anyone they supervise into custody for a violation or commission of new crimes.

  Pretrial, probation and parole should work closely with victims and victim advocates to inform their recommendations (to courts and at parole violation hearings) and how they manage offenders while on supervision. They need to know about re-entry services for offenders if there is to be a sentence served and which offender intervention programs provide an effective, accountable program that engages the offender and works closely with the victim advocates AND the criminal justice system.

- **Health care** systems are instrumental in responding to both IPV victims and perpetrators. In systems that provide care to the entire family unit, providers may treat both victims and perpetrators of IPV. They provide a range of screening, assessment, and treatment options for PTSD, TBI, substance use disorder (SUD) and depression. They may also conduct IPV screening, and respond to urgent situations that require a medical response.

- **Mental health and substance abuse programs** offer specialized treatment for individuals suffering from mental health disorders like PTSD and depression as well as substance abuse. Professionals within these programs often work with survivors of traumatic experiences. They may or may not have specific resources and interventions for IPV victims and perpetrators.

- **The Veterans' Health Administration (VHA)** is the health care arm of the VA. The VA provides a full range of screening, assessment, and treatment to include mental health services, substance abuse treatment, medical services, rehabilitation (physical and work rehabilitation), homelessness services, and military-specific trauma treatment. However, while the VHA is working on increasing the number of satellite clinics in communities around the nation, there remain many rural communities without any type of VA facility. It is important for community partners to understand what is available to veterans and what options exist for those without local services. Currently, specific services for IPV victims and perpetrators vary across the VA system.

- **Offender intervention programs** (often referred to as Batterer Intervention Programs—BIPs) offer IPV perpetration rehabilitation services to identified IPV perpetrators. In doing so, they may conduct a full mental health and substance abuse assessment, in addition to an extensive assessment of the pattern of IPV perpetration. Some offender intervention programs may also have requirements regarding the type and frequency of contact the program makes with victims. They generally make these contacts through victim advocates. Most states have requirements that programs must adhere to, to become state certified and compliant with state guidelines. In addition to type and frequency of victim contact, these requirements address aspects of the program to include program philosophy (e.g., no victim-blaming language), length of program, training and credentialing of program staff, group size, and ongoing monitoring of the program.

A CCR approach to IPV is key to ensuring that all the interveners in a community communicate that IPV is not acceptable and that offenders will be held accountable. Most IPV victims seek help from informal sources, such as friends, family, neighbors, or employers first. Only a small percentage ever go to a shelter or the police for help. A CCR alone will not stop the violence, but it is a first step in ensuring that a consistent message is spread throughout the entire community. For information about military-civilian CCR projects that involve collaboration between active duty military installations and civilian communities, see Appendix A.

Screening at Community Points of Intervention

The following section outlines the roles and responsibilities of community points of intervention and recommendations for screening and assessing service members and veterans who are experiencing IPV and co-occurring problems. These points of intervention have very different roles and responsibilities and would conduct the type of screening or assessment that is appropriate to their

intervention. However, since the co-occurring conditions may have a profound impact on severity and frequency of IPV and potential lethality, it is important that ALL points of intervention understand their role and responsibilities in determining if any of these conditions exist and what actions to take if they do. It is important for each point of intervention to conduct its own screening, and not rely solely on information from other agencies.

Screening for Military Service and War/Conflict Zone Deployments

Cultural Awareness and Sensitivity

The following thoughts about cultural awareness and sensitivity are excerpted with permission from the Praxis International Blueprint for Safety, Training Memo, Justice-Involved Military Personnel and Veterans (Tinney & Strand, 2010).

> Knowing something about military/veteran culture can be helpful to the professionals in all settings who respond to them. Some veterans have belief systems about military versus civilian and continue to think of themselves as military. To them, anyone who has not served in the military is considered a civilian. These veterans have expressed reluctance to talk about their military experiences, particularly combat experiences, with anyone who has not served. For some veterans, this goes a step further where they will not talk about combat experiences with anyone except other veterans who also have combat experience.
>
> Beliefs and behaviors stemming from past military experience may also persist. For example, some veterans express strong opinions about the use of firearms: "Do not draw a firearm unless you intend to shoot." "Do not shoot unless you intend to kill." This is important information for law enforcement who may respond to a domestic disturbance. Knowing whether either spouse is a military service member or veteran and whether firearms are present is critical to determine the potential dangerousness of the situation.
>
> Understanding these beliefs may be helpful in forming a working relationship with a service member or veteran in any setting. Across systems, from health care professionals to law enforcement, it is helpful for the professional to let the service member or veteran know if he/she is also a veteran and possibly deployed to a war zone. For individuals who are not themselves service members or veterans but who have family members who are (e.g., a spouse, son or daughter, parent/s, etc.), it may also be helpful to share that information to facilitate a working relationship. By doing so, a level of credibility is immediately established, reducing the barriers to communication.

Military culture where secrecy and security is valued, and sometimes necessary, creates a strong distinction between "soldiers/civilians" (Gerlock, Grimesey, & Sayre, 2014). In intimate relationships, this leads to a sense that partners cannot understand what the service member or veteran is experiencing. Strong distinctions between "soldier and civilian," in which the military veteran continued to think of himself as "soldier" and his wife/partner as "civilian" were associated with significantly impaired communication and being highly distressed in couples participating in the *Relationships and PTSD Study: Detection of Intimate Partner Violence* (Gerlock, Grimesey, & Sayre, 2014).

Military Service Screening Questions

Screening for military experience can be accomplished with a few questions, (also found in Appendix B).

- Have you ever served on active duty in the Army, Navy, Air Force, Marines or Coast Guard or in the National Guard or Reserves? If yes, ask:
    - Which service?
    - When?
    - What was your job in the service?
    - Did you receive specialized training? If yes, ask:
        - What type of training?
- Have you ever deployed to a war zone? If yes, ask:
    - How many times?
    - Where?
    - When?
- Do you have combat experience? If yes, ask:
    - Where?
    - When?

These screening questions can be tailored to the setting and situation. For example, 911/dispatch may ask, "Did your husband/wife, boyfriend/girlfriend ever serve on active duty in …?" and then proceed from there. The same screening procedure can be easily implemented **at all points of community intervention** and will help determine the need for additional screens or possibly full assessments and referrals. If working with someone with war zone deployment and/or combat exposure, screening questions about PTSD, TBI, and depression, and suicide may also be indicated. Therefore, it is recommended that a simple military experience screening be conducted at all points of intervention.

Screening/Assessment for IPV Perpetration by Point of Intervention

Screening for IPV perpetration may be conducted with a few questions in any setting. In **law enforcement, criminal justice, correctional, pretrial/probation/parole**, and **offender intervention** settings, screening for IPV-related issues should be conducted if IPV is an element in a crime. If there is no capability to conduct further assessment, protocols should be in place to refer for further assessment if there is a positive screen for IPV. Screening and assessing for IPV perpetration is not different for military personnel and veterans. Military-related IPV perpetrators use the same abusive tactics as the general population of IPV perpetrators.

An IPV assessment tool was developed for this document that combines military and combat experience information with IPV assessment information. The tool provides a way to document information about military and combat experience, combat-related co-occurring conditions, medical and mental health problems, and pertinent information about history of IPV. The assessment tool is found

in Appendix C**.** The same information is needed to determine what is occurring, the risk to the partner, and how to intervene to ensure safety.

IPV Perpetration Screening

Quick screens for IPV generally include three or four questions focused on physical and/or sexual violence and can be used in **all settings**. Additional questions may be added to identify patterns of coercive control. Appendix D provides an example of screening questions that focus only on IPV perpetration, although these questions are intended as part of a bi-directional (both victim and perpetrator) screen (Jaeger, Spielman, Cronholm, Applebaum, & Holmes, 2008). IPV perpetration may be identified when a bi-directional screen is conducted. When IPV perpetration is present, most settings will need additional assessment to determine if there are any immediate threats to the victim, others, or intended self-directed harm. While this document focuses specifically on IPV perpetration, there are excellent resources to help guide screening and assessment for IPV victimization.[1]

***Assessment Tip:** When screening for IPV perpetration, principles regarding the safety of victims and their children are still a priority, such as not interviewing them in the presence of the perpetrator. How this is done will depend on the setting. Additionally, once the primary IPV aggressor is determined, it is important to hold the perpetrator accountable when discussing the IPV.

IPV Perpetration Assessment

The response to a positive screen for IPV perpetration will depend on the situation and setting. **Law enforcement** will use this information, in addition to other information (e.g., the evidence at the scene, IPV history of parties involved, witness statements, etc.), to determine who is the victim and who is the perpetrator, and the level of crime committed. They will use this information to decide who to arrest and to whom they will provide victim services information. Members of **the justice system** may request or conduct further IPV assessments (from either the victim or perpetrator, or both) to assess danger and lethality of the situation and type of resources or treatment needed.

There are a number of valid and reliable tools to assess IPV **patterns**. For example, the Abusive Behavior Inventory (ABI) (Shepard & Campbell, 1992) includes a rating scale that asks about the frequency of both psychological and physical abuse. It includes a form for both the perpetrator (self-measure of frequency of abuse and violence) and victim (measure of frequency of abuse and violence victimization). The ABI is found in Appendices E and F.

Screening for IPV Perpetration: Law Enforcement

Police dispatch/911 operators and **law enforcement/detectives** ask questions to determine what happened. Responders and dispatchers need to know if weapons were involved and if injuries have occurred. If so, they will need to determine if they need to dispatch medical response. Dispatch may keep a victim on the line while law enforcement is in route. 911 operators use this time to determine additional factors that may impact safety (see Risk and Danger, below). Law enforcement/detectives investigate for both IPV victimization and perpetration to determine the

[1] For example, Futures Without Violence provides a toolkit, available online, on IPV screening and counseling (see: http://www.futureswithoutviolence.org/)

primary victim and the primary aggressor. Screening questions are asked by both dispatch and law enforcement to determine if IPV is an issue and if children, other family members, or new intimate partners may be at risk for injury or death.

Screening/Assessment for IPV Perpetration: Justice System

Settings within the **justice system** will want to assess to some extent about IPV, depending on the setting and role/responsibilities. An assessment will include the basic information gathered from the screen but is expanded by adding additional elements to include collateral information, level and type of intervention needed, disability or functional impairments of either the offender or victim, strengths and supports, response/s to prior treatments or interventions (if applicable), and the offender's level of motivation and readiness for treatment/change.

All settings should be able to assess for immediate threat of danger (if, for example, the perpetrator has threatened to injure or kill the victim, him/herself, the victim's children, or anyone else), and have protocols in place to respond to situations of imminent threat. The type of response will also depend on the setting. Settings that work directly with the perpetrator will want to include an IPV perpetration and risk assessment as part of monitoring. Assessing for risk and danger is covered in the next section of this document.

Both **defense** and **prosecution** teams, as well as **court** and **specialty courts**, **pretrial/probation/parole**, **medical** and **mental health/substance programs**, and **offender intervention programs** should be able to assess for ongoing risk of harm: the pattern of physical and psychological abuse and whether the violence has escalated, the presence of weapons, drug or alcohol use, suicide threats, and stalking, and victim efforts to gain independence. Response to this assessment will depend on the setting. In the **justice system**, this information will inform the type of sentence and level of monitoring for **pretrial/probation/parole**. **Courts** will need this information to determine the type of court-ordered interventions required for the perpetrator. Additionally, they will want to know about risks of reprisal from either the perpetrator or the victim, as that provides further information about the overall danger of the IPV situation. The **defense team** will gather and access the same information as the prosecution team. However, their focus is on defending the accused. When a crime has clearly been committed, they may be involved in making a case that the identified perpetrator was acting in self-defense or was fighting back (e.g., in the case of an IPV victim defendant). They may start with a screen for IPV victimization to determine if a more thorough assessment is needed.

Pretrial/probation/parole will be able to monitor compliance with court orders and usually require a copy of the assessment (general mental health, substance abuse, and IPV perpetration) from the **offender intervention program**. They may administer questionnaires to assess the risk of re-offense but will maintain ongoing contact with **offender intervention programs** (through oral and written contact) as one way of continuing to assess risk and danger.

Screening/Assessment for IPV Perpetration: Community Programs

Community programs (e.g., **health care**, the **VA**, and **treatment programs**) will want to assess as follows, depending on the setting and role/responsibilities.

All settings should be able to assess for immediate threat of danger (if, for example, the perpetrator has threatened to injure or kill the victim, herself or himself, the victim's children, or anyone else), and have protocols in place to respond to situations of imminent threat. The type of response will

also depend on the setting. Settings that work directly with the perpetrator will want to include an IPV perpetration and risk **assessment** as part of monitoring.

When IPV perpetration is identified, c**ommunity settings** (medical, mental health, and substance abuse treatment programs) need to develop protocols to assess the pattern of violence and risk/danger elements and can respond to an imminent threat of suicide or homicide. As in a general health care setting, positive screens in a situation where there is also imminent threat will require immediate action. Protocols to respond to imminent threat should also be in place.

Emergency rooms and **primary care** settings will assess and treat life-threatening injuries to the perpetrator resulting from the violence or the victim fighting back. Health care professionals will want to assess the impact of IPV on the perpetrator's health (injuries and acute or chronic illnesses) and how the abuse has affected his/her health and that of family members. They will also want to schedule a follow-up appointment and convey the importance of IPV as a health issue that impacts everyone in the family.

There are several reliable tools for screening for both IPV victimization and perpetration in a health care setting. One source, Futures Without Violence (formerly Family Violence Prevention Fund), has developed National Consensus Guidelines on Responding to IPV Victims in Healthcare Settings (Family Violence Prevention Fund), along with Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers (Ganley, Fazio, Hyman, James, & Ruiz-Contreras, 1998). Routine screening in health care settings emphasize the importance of universal screening irrespective of gender, because IPV can happen in heterosexual as well as gay and lesbian relationships, and both men and women can be primary IPV perpetrators as well as victims. Universal screening does not require disclosure of abuse or violence, but builds on providing education on healthy relationships and the impact of violence and abuse on the health of family members. This opens the door for disclosure in the future, and engages the patient/client in change (Gerlock & Ganley, 2016).

Offender intervention programs are can regularly monitor the perpetrator's pattern of abuse and violence and determine if the individual is amenable to, and responding to, treatment. These programs need criteria on how to measure the pattern of abuse and violence and have clear expectations of what is expected at each phase of treatment. Whether or not an individual is court-mandated for treatment, offender intervention program staff will conduct danger/risk assessments and follow their state guidelines, if applicable, for victim contact.

Medical, substance abuse, and **mental health** settings conduct screens and assessments for a wide range of health-related problems but may need to establish an IPV screening protocol. When IPV victimization or perpetration is identified, an additional assessment is needed to determine risk and danger issues, conduct a safety assessment, and identify resources/referrals and next steps. Positive screens may require immediate attention (as in the case of a positive screen for suicide with intent, means, and plan, or IPV perpetration with an imminent intent to harm a victim) (Gerlock, Grimesey, Pisciotta, & Harel, 2011). Positive screens where there is no immediate threat will require a more thorough assessment, and/or referral to a specialty clinic. While most medical settings have protocols in place to respond to positive screens for IPV victimization, many medical settings do not have protocols in place to respond to IPV perpetration. It is recommended that non-judgmental screening for both IPV victimization and perpetration and targeted interventions that include protocols for assessment and response to immediate threat be implemented.

Not all **VA** facilities currently routinely screen for IPV victimization and perpetration. Some VA medical centers have hospital-specific screening in place in some areas (e.g., primary care and mental health), but these are not part of the nationally-mandated clinical reminders. However, in 2012 the Veterans Health Administration organized a Domestic Violence Task Force to facilitate research and development of a National Domestic Violence Program. Routine screening, further assessment for a positive screen, and intervention for IPV victimization are being implemented as part of the VA National IPV Assistance Program with implementation of screening, assessment, and intervention for IPV perpetration to follow.

Risk/Danger Assessment by Point of Intervention

An assessment for risk and danger should be done by anyone in any setting where IPV is identified. The type of assessment and response will depend on the setting. Factors that affect danger in IPV situations are numerous and can change quickly. Through research and focused state domestic violence fatality reviews, understanding of these factors has improved. It is easier to identify situations that are potentially dangerous than it is to know when a situation will become fatal. No instrument for assessing dangerousness should be a substitute for listening to victims and survivors and learning about the context of their current situation and the complexity of their lives.

The victim is usually the best source of information about the IPV, for a variety of reasons, but also has the most to lose by disclosing it. A perpetrator is likely to assume that his/her high-risk rating is the result of his/her partner "telling on him/her." He/she may respond with retaliation and intimidation. Drawing from additional sources of information (police reports, 911 calls, court records, past compliance with pretrial/probation/parole and treatment recommendations) can diffuse the source of information, improve results, and protect victims from having high risk behavior directly tied to their statements (Gondolf E. W., 2012). Gathering information from and about the perpetrator can inform a practitioner's understanding of both the current and potential danger posed by the perpetrator.

One example of a tool for assessing the level of danger that a victim has of being killed by her/his intimate partner is the Danger Assessment (DA), an instrument developed by Dr. Jackie Campbell from Johns Hopkins School of Nursing. This tool was originally developed to be used in a confidential setting in the healthcare system. The tool has since been applied in other settings that do not quarantee confidentiality. The use of the DA in a non-confidential setting requires that victims be given enough information about who will have access to their information now and at a later date, so they can give informed consent to answer the questions or refuse to answer the questions. For access to and training on the use of the Danger Assessment, go to www.dangerassessment.org.

There are a number of researchers who discuss risk and danger issues when IPV is present (Campbell, Sharps, & Glass, 2000; Campbell J. C., 1995; Campbell, et al., Assessing risk factors for intimate partner homicide, 2003; Messing, Campbell, Wilson, Brown, & Patchell, 2015; Websdale, 2000).

When assessing for risk and danger, thoughts of suicide and homicide should be asked of both IPV victims and perpetrators. The risk/danger assessments found in Appendices G and H were developed as part of a research protocol (Gerlock A. A., Relationships and PTSD Study: Detection of Intimate Partner Violence (NRI 04-040), 2011) and may be helpful in identifying escalating patterns of violence or in determining if thoughts of suicide or homicide are present. Each point of intervention will have a different role in responding to imminent risk. It is important to remember that thoughts of suicide and/or homicide can change rapidly depending on a variety of life circumstances for either the

perpetrator or victim. Screening and assessment for risk/danger elements should be ongoing at each point of intervention.

IPV risk assessment has been recommended for use across criminal justice and advocacy settings to determine which offenders are at risk for perpetrating future violence and homicide (Bennett, Goodman, & Dutton, 2000; Campbell, 2004; Gondolf E. W., 2012; Hilton, et al., 2004; Kress, Protivnak, & Sadlak, 2008; Roehl & Guertin, 2000; Roehl, O'Sullivan, Webster, & Campbell, 2005).

Risk/Danger Assessment: Law Enforcement

When it comes to IPV, **911 and dispatch** personnel are frequently in a situation of making quick determinations about the immediate danger of the situation, as most 911 calls are for urgent or emergency situations. Operators quickly determine some of the factors that affect the danger, to include if firearms or weapons are present and if they have been used, if there are injuries, if anyone is under the influence of drugs or alcohol, if the perpetrator is still there, and other relevant information.

Once on the scene, **patrol officers** will further assess the danger of the situation, as it may have changed since the 911 call. The perpetrator may have left the scene or there may have been injuries or death since the call was made. Once again, law enforcement personnel are in the position to make a rapid assessment of the situation and risk/danger. Many communities have implemented a risk assessment protocol for law enforcement. One such tool, The Lethality Screen, is intended to screen victims into a brief advocacy intervention (Messing, Campbell, Wilson, Brown, & Patchell, 2015).

They may consider any co-occurring conditions that affect the situation (e.g., a post-deployment or mental health issues affecting the perpetrator's awareness of what is happening; whether he/she is in a flashback or dissociative episode; or level of intoxication).

In the case where the individual is depressed and suicidal, officers must again make quick decisions about the danger of the situation and how to respond. They will need to determine if weapons are present and if they have been used. The law enforcement response will depend on the situation and the determination of the best approach. Responding to someone in a flashback is different from responding to someone who is acutely suicidal and will require some variation in strategies to intervene and a proper screening and/or assessment can help law enforcement better adjust their approach.

Investigators may also be in a position to assess imminent threat, especially if the suspected perpetrator is still at large. In that case, they too will need to determine factors that affect the immediate danger to include access to the victim(s) and weapons and the perpetrator's psychological state (mental health or substance abuse problems). Investigators work with patrol officers to gain additional information through witness statements from people who are aware of the crime or who know the suspect.

People who are incarcerated may still pose a threat. They may express self-harm or may be making threats to and/or intimidating victim(s) either directly (through phone calls or during visits) or indirectly through a third party. **Correctional officers** can monitor the inmate's psychological state and access to anything they could use to hurt themselves or others. Correctional officers are often the first to identify and alert jail/prison medical staff if an inmate's medical or mental health is deteriorating and are in the perfect position to conduct risk/danger screenings and make recommendations for assessments.

Risk/Danger Assessment: Courts, Prosecution, Pretrial/Probation/Parole

Members of the **justice system** must also be aware of factors that affect danger. Court appearances can be highly emotional and may bring the perpetrator in contact with the victim. Because of the potential risk of IPV homicide at court appearances, courts ban weapons and most screen everyone entering court. It is impossible to know for certain when an IPV situation will become lethal. After disastrous situations where the court became an IPV homicide scene, precautions have been implemented which assume that any case could be potentially lethal. **Specialty courts** are under the same precautions; however, staff may have also conducted danger assessments through assessment tools and face-to-face interviews. This information will help inform court decisions regarding the type of sanctions, intensity, and type of monitoring (to include frequency of court review and substance testing).

Victim advocates, working with **prosecution**, may have also conducted danger assessments along with in-depth interviews with the victims to gain a better understanding of both immediate and potential risk. This information will help prosecution argue against allowing bail (if the circumstance is potentially too dangerous for the victim/s), as well as asking the court to require sanctions based on the identified risks. **Defense** may also request additional assessments (to include those already addressed) to determine if certain risks are modifiable (i.e., will treatment for mental health or substance abuse problems reduce risk?). Defense may request specified treatment based on those assessments.

Pretrial/probation/parole personnel are in a position of monitoring risk and danger as long as they are working with a perpetrator. They too may conduct risk and danger assessments. However, the dangerousness of the situation could rapidly change. One "snapshot" of danger is just one period in time. While a snapshot may help with the overall understanding of the danger elements, it is not static. Any of the danger elements could change at any time making a lower-level danger situation critically dangerous. If the situation becomes dangerous, law enforcement can be dispatched to the location of the perpetrator. If the perpetrator has violated court orders, they can be re-arrested, spend additional jail time, and have additional court sanctions.

Risk/Danger Assessment: Community Programs

Community programs including hospitals, mental health clinics, and substance abuse programs are also in a position to assess risk and danger. **Mental health clinics**, **VA facilities,** and **substance abuse programs** routinely ask about suicidal thoughts and intent and have protocols in place to respond to imminent risk (positive screens). However, it is less likely that they are asking about IPV and unlikely they are asking about thoughts of homicide. For this reason, it should be routine for all hospital, mental health, VA facilities, and substance abuse programs to screen for IPV victimization and perpetration and have protocols in place to respond to clients experiencing depression and/or with thoughts/intent of both suicide and homicide – risk factors for dangerous situations.

Offender intervention program staff can are also monitor risk and danger for the entire period the perpetrator is in the program and work with pretrial/probation/parole help monitor the danger level and keep them informed about changes to risk or interventions taken. They too should conduct risk/danger assessments to get an overview of the risk and danger. An IPV perpetrator assessment will usually include an assessment of the pattern of abuse and violence, as well as other risk elements. However, they must keep in mind that risk and danger is dynamic and could change rapidly. They may also have a working relationship with victim advocates or state requirements to inform victims about changes in the perpetrator's status (e.g., dropping out of the program, failure to comply with program requirements, non-compliance discharge, etc.).

Screening/Assessment for Co-Occurring Combat-Related Conditions

PTSD Screening/Assessment and Points of Intervention

The PTSD Screening Tool in Appendix I was developed for primary care medical settings and consists of four questions. An additional assessment may be needed, and a determination of a PTSD diagnosis would require a thorough assessment by a person experienced in conducting that type of evaluation and credentialed to diagnose. This PTSD screen can be used to screen for both military and non-military-related trauma in all settings. When a service member or veteran is identified, it is a useful screen to determine if PTSD is present secondary to either military or non-military related experiences.

PTSD Screening/Assessment: Justice System

In **correctional settings**, corrections officers are likely to witness and possibly respond to PTSD-related symptoms (e.g., startle responses or aggressiveness) if they impact the safety of the inmate or others, and they may request a thorough mental health assessment and intervention, especially in the case of a positive PTSD screen. Members of the **justice system** may also use this screen as a starting point to determine factors that may affect the level of danger (i.e., the co-occurrence of both IPV perpetration and PTSD) and to make recommendations regarding sentencing or to request treatment. In the case of **defense**, they may start with this screen to determine if more assessment is needed to determine if there is any relationship between PTSD and the crime. In the case of Veterans Treatment Courts (**VTCs)**, the VA Veteran Justice Outreach (VJO) specialist may be able to conduct a thorough PTSD assessment or may facilitate an assessment at the VA, Vet Center, or through specific state services for veterans. However, other specialty courts (e.g., mental health courts and alcohol/drug courts) may need to implement PTSD screening to determine if additional mental health services are needed. Beyond the VJO specialist, it is unlikely that anyone from the justice system points of intervention will have the expertise to conduct a full assessment. However, such expertise is available through community medical settings or the VA. **Pretrial and probation** may initially screen for PTSD to determine if additional services are recommended or required for the perpetrator to improve compliance with court sanctions and improve community stability.

PTSD Screening/Assessment: Community Programs

Community programs should be able to screen for PTSD, but the response will depend on the setting. For example, all **health care** settings should be able to screen for PTSD since military personnel and veterans, as well as non-veterans, may present with PTSD-specific symptoms and require an additional assessment and treatment. **VA health care** settings and Vet Centers already have a specific PTSD screen in place and provide specialty care for individuals presenting with PTSD symptoms. **Substance abuse** and **mental health programs**, in particular, need to have PTSD screening in place to determine if additional services are needed. **Offender intervention program** staff should be able to screen for PTSD, as they too may have individuals with co-occurring PTSD symptoms. They should also be aware of how PTSD symptoms may impact the frequency and severity of IPV perpetration. Military service members and veterans may attribute all their aggressive behaviors to PTSD symptoms, or may challenge program staff about their knowledge of military-related issues. Additional services for PTSD screening, assessment, and treatment may be available through local Vet Centers, VA health care settings, or state departments of veteran affairs services. Community mental health services are also an option for PTSD screening, assessment, and treatment.

A PTSD assessment involves more than a few questions. To fully assess an individual for PTSD, a discussion about the traumatic experience/s will need to take place to determine the nature of the trauma and the impact on the individual. A PTSD diagnosis involves clusters of symptoms, which include

re-experiencing, avoidance, negative alterations in cognitions and mood, marked alterations in arousal and reactivity, duration of the disturbance, level of stress and impairment, and not due to other physiological effects of substance or another medical condition. Thorough questions addressing each of these symptom clusters and the level of life dysfunction need to be asked to determine the level of impairment and treatment needed. A PTSD assessment and diagnosis should be done by qualified mental health professionals with expertise in PTSD.

TBI Screening/Assessment and Points of Intervention

While both military and civilians may experience TBIs, veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are particularly at risk. With as many as 30% of these veterans experiencing injuries to the head and neck during their deployment, the ability to screen for TBI is important in many settings (Taber & Hurley, 2010). Of the OIF/OEF veterans sustaining traumatic brain injuries, most (estimated between 70-80%) are considered mild (mTBI). (Defense and Veterans Brain Injury Center, n.d.; The Management of Concussion/mTBI Working Group, 2009).

A **screen** to determine military-related TBI involves a few questions and is only a screen to determine if a brain trauma occurred. It is unlikely that screening for a TBI will be conducted by **dispatch** or **law enforcement**. A service member or military veteran may mention they sustained one or more TBI's during their deployment, in which case, this information should be passed along to justice system personnel to determine if a screen and thorough assessment are needed. Establishing a diagnosis of a TBI needs to be **done by a health care professional** with that expertise. However, the questions found on the TBI screening tool in Appendix J will help clarify if a referral needs to be made. The questions contained with this specific TBI screening tool are specific to military-related brain injuries. However, the symptoms listed for the time of the injury, and symptoms that have persisted over time are relevant to non-military TBI's as well.

A specific **TBI assessment** may or may not be indicated. Symptoms from a mild TBI generally clear in a few months and will not require additional assessment. If a person who has sustained multiple mTBIs, has recently returned from a deployment or has sustained a moderate to severe TBI, an assessment may be warranted for certain settings (Taber & Hurley, 2010). Only **qualified medical professionals** will be able to conduct an assessment for TBI and make that diagnosis. However, professionals in a range of settings can screen using a tool like the one in Appendix J to determine if additional assessment is needed.

TBI Screening/Assessment: Justice System

While a TBI screen could be done in any setting, certain settings are more likely to need a screen to determine if additional information is needed. **Correctional officers** may want to screen for TBI or request an assessment and assistance, especially if the military experience screening finds the inmate was recently back from a war-zone deployment and is behaving in a manner that may affect his/her safety or the safety of others (e.g., directing aggression toward himself/herself or towards officers, jail staff, or other inmates; dizziness or other symptoms possibly related to a TBI).

The **defense team** may conduct a TBI screen if a brain injury seems to be affecting the defendant's behavior (either as it relates to elements of the crime or the ability to benefit from court-ordered treatment). If the defendant has a positive screen, if aspects of the crime appear to be affected by TBI symptoms, or if a TBI makes it difficult for the individual to respond successfully to court stipulations, defense may request a TBI assessment. **Pretrial and probation** may also identify an individual with a possible TBI and should be able to screen to determine if a more thorough assessment

and treatment is indicated. This is particularly important for pretrial and probation because they may determine that symptoms related to a brain injury are interfering with the perpetrator's ability to benefit from other court-ordered interventions and/or comply with conditions of pretrial release or probation. **VTC personnel** may identify a service member or veteran with a recent war-zone deployment and exposure to blast injuries and make recommendations for further assessment if it appears that a brain injury may impact his/her ability to comply with court sanctions.

TBI Screening/Assessment: Community Programs

Community **medical settings** (to include general medical settings and **mental health** and **substance abuse treatment programs**) should have screening in place, especially with the large number of military service members returning from deployments to Iraq and Afghanistan and accessing civilian medical care. If a TBI is identified, further assessment and treatment may be needed for the individual to respond successfully to mental health and SUD treatment interventions. The **VA** (medical centers and Vet Centers) routinely screen all veterans returning from deployments to Iraq and Afghanistan for TBI. Most community **medical centers** have expertise available to conduct a thorough TBI assessment. Community **medical centers**, **VA facilities**, and military medical settings may have poly-trauma clinics and programs available to provide both assessment and intervention.

Offender intervention programs should also have TBI screening in place. Recent TBIs (within the past few weeks, possibly up to three months) and moderate to severe TBIs can impair concentration and memory and may interfere with a perpetrator's ability to benefit fully from the program. Veterans with TBI and PTSD reporting concurrent anger/irritability have been shown to have reduced treatment adherence and an increased rate of PTSD treatment dropout (Forbes, et al., 2008) and are more likely to be arrested (Elbogen E. B., et al., 2012). Additionally, a moderate to severe TBI may increase impulsivity and impact the dangerousness of the IPV when both IPV and TBI are present. Offender intervention program staff may refer the individual for an assessment if he/she meets TBI screening criteria and TBI-related symptoms appear to be interfering with the ability to work with program materials and meet expectations. Offender intervention program staff may want to work with medical staff to tailor the program to assist the perpetrator in successfully working with the program materials.

Substance Abuse Screening/Assessment and Points of Intervention

Screening for alcohol or drug use and abuse can help determine if a person has a substance abuse/misuse problem and can clarify if a person would benefit from a more thorough assessment. The level of *current* (i.e., at the time of the test) alcohol intoxication can be done through breath and/or blood analysis. The type of drug, and in some cases the *current* blood concentration, may be obtained through a urine or blood analysis. Identifying and diagnosing an SUD would need to be done after a thorough **assessment** by a professional with that expertise. However, the Alcohol Use Disorders Identification Test (AUDIT-C) and/or CAGE Questionnaire in Appendix K can be done by anyone who is willing to ask the questions in a private, verbatim, nonjudgmental fashion.

To determine quickly if drugs are an issue, it is necessary to ask what drug(s) and how much of each type was used. The Drug Abuse Screening Test (DAST) is a reliable screening tool to determine drug misuse/abuse (Skinner, 1982). The DAST-10, which is found in Appendix L, is a shortened version that maintains reliability and is used for screening purposes only. Drug abuse refers to the use of either prescribed or over-the-counter drugs in excess of the directions, as well as any nonmedical use of drugs.

An assessment is conducted through an interview process and involves a more thorough review of the level and pattern of substance use, the resulting problems from the use, and history of prior

treatment and response to treatment. The assessment may also include findings from breath, urine and/or blood analysis, and response to screening tools.

Substance Use Screening/Assessment: Law Enforcement

For law enforcement personnel (e.g., **911, dispatch, and police**) identifying how much someone has had to drink within the past few hours, or over the past few days, is helpful in determining if someone is acutely intoxicated or possibly going through withdrawal. In some cases, when a person is significantly, acutely intoxicated, law enforcement may also need to gather information from available collateral sources (evidence of substances used, witnesses on site, family/friends/housemates, or others). While self-report is usually reliable in identifying a substance use problem, it does not fully identify the range and scope of the problem. Answers to the screening questions will provide information about a person's general drinking and drug use patterns. The number of drinks needed to become acutely intoxicated will vary depending on a person's usual drinking pattern (as well other factors to include age and gender). Someone who drinks four or more drinks daily, or almost daily, may not appear intoxicated because of habituation to alcohol; although cognitive performance may still be impaired. Law enforcement personnel also need to know about drug intoxication and should ask questions about type and amount of drug(s) recently used, as well as any psychological or behavioral problems that may be related to drug use. Fear of negative consequences (for either a victim or perpetrator) may result in reluctance to self-report either alcohol or drug use or related problems. In this case, collateral information may be required to establish current use and level of intoxication. A breathalyzer screen may be requested or required at the time to establish level of intoxication. Medical transport may need to be arranged if a person is acutely intoxicated and incoherent or non-responsive.

Substance Use Screening/Assessment: Justice System

Correction officers will need to be aware of the inmate's recent intoxication because of the risk of acute withdrawal or delirium tremens, which can set in within 72 hours or up to several days for someone with significant alcohol dependence. A person going through acute alcohol intoxication withdrawal may require emergency medical attention. Similarly, they need to know about any acute drug intoxication, which would impact the safety of the inmate and require medical attention. For example, acute intoxication of phencyclidine (PCP) may have a psychiatric presentation of experiencing hallucinations or delusions or acute depression and suicidal thinking. Alcohol and/or drug intoxication may be an element in a crime, as is often the case with IPV. Individuals presenting with acute intoxication may require medical clearance before booking and will receive alcohol and/or drug urine or blood screening to determine type and level of substance ingested.

When available, results from breath, urine, and/or blood analysis may be relevant information for both **prosecution and defense teams.** Either may request an additional alcohol and/or drug screen to determine if an SUD is a problem for the defendant and if a more thorough assessment is needed. For individuals with significant long-standing problems with substance dependence, a period of abstinence may be required to differentiate behaviors associated with acute intoxication and other co-occurring mental health disorders like depression and PTSD. Some jurisdictions have **specialty alcohol/drug courts** and have staff available to conduct alcohol and drug abuse screening. A more thorough assessment is conducted by a community-based addiction specialist. The assessment may be required by the court to help inform sentencing and release requirements (e.g., ongoing alcohol/drug testing). The court may mandate drug and/or alcohol treatment as part of the sentencing and require ongoing drug and/or alcohol monitoring. Upon identifying an SUD through a screen, **pretrial or**

probation may require a more thorough assessment as well as requiring substance use monitoring through specified alcohol breathalyzer or drug urine analysis.

Substance Use Screening/Assessment: Community Programs

Health care community settings have staff available to conduct alcohol and drug screening and assessment. These settings may also have specific SUD treatment services available. Identifying alcohol and drug misuse/abuse is important in health care settings because of the profound, deleterious effects on health.

Both **VA medical centers** and **Vet Centers** have staff qualified to conduct alcohol/drug screening and assessment. **Mental health** settings routinely screen and assess for SUDs. Symptoms of acute intoxication or withdrawal can manifest as mental health disorders. A co-occurring substance use disorder may exacerbate other major mental health disorders, just as people with major mental health disorders may use substances to help them cope with psychiatric symptoms or intolerable life circumstances. Ongoing substance abuse interferes with response to treatment and could be dangerous when combined with prescribed medications. There are **substance abuse treatment programs** available in community settings as well as VA and military medical settings.

It is especially important for **offender intervention program** staff to be aware of an offender's SUD. Abstinence may be a condition of sentencing or release and ongoing substance monitoring may be required, in addition to offender treatment. Active alcohol and/or drug abuse may interfere with a perpetrator's ability to work with program materials, may be contributing to the pattern and severity of abuse and violence, and/or may increase risk and danger. Because not all IPV incidents involve alcohol or drugs, but because substances may still be a problem for a perpetrator, screening for both alcohol and drugs should be available, and referrals should be made for more thorough assessment. If substances are identified as a problem, offender intervention program staff should require additional substance use treatment and monitoring as part of the program requirement. A period of abstinence may be required prior to starting an offender intervention program.

Depression Screening/Assessment and Points of Intervention

As with the previously identified co-occurring problems of PTSD, TBI and SUD, depression can affect IPV in a number of ways for both the victim and the perpetrator. Depression is one of the mental health disorders that frequently co-occur with PTSD and SUD. Depression can also impact an individual's response to treatment; people with undiagnosed and untreated depression may not respond well to court-ordered treatment. Depression and suicidal thinking have also been linked to IPV homicide and suicide in fatality reviews across the nation and internationally. For this reason, screening and assessing for depression is important in a range of settings.

Depression screening can be done quickly in any location that provides a private setting to ask a few questions. Appendix M is an abbreviated version of the longer Patient Health Questionnaire-9 (PHQ-9) which is frequently used in health care settings, (The MacArthur Initiative on Depression and Primary Care at Dartmouth College and Duke University, 2004, 2009; The MacArthur Initiative on Depression and Primary Care at Dartmouth College and Duke University, 2004a, 2009a) using only the first two questions of the longer 9-question screen. The PHQ-2 asks two critical questions to help determine if someone is depressed. However, it is **important** to remember a negative screen may not mean a person is not depressed, just as a positive screen may not mean they are depressed. For this

reason, if an individual appears to be depressed (whether or not there is a positive screen), it is important to be able to refer to a qualified **medical or mental health professional for a full assessment**.

While a quick screen for depression establishes some key indicators (loss of interest/pleasure and feeling down and depressed), a full assessment by a qualified professional includes additional questions about sleep patterns, energy level, appetite, concentration, feelings of guilt or shame, slowed movement or restlessness/agitation, and thoughts of harming oneself or a death wish. It also includes questions about onset of the depression and whether the person has had depression before (and what was done), or whether it runs in the family. A **mental health professional** may also conduct additional testing using specifically developed tools. There are many valid and reliable tools to assess depression. For example, both the Beck Depression Inventory (BDI) and Zung Self-Rating Depression Scales are available online but should be conducted and scored by someone knowledgeable in their use (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Zung, Richards, & Short, 1965).

Depression Screening: Law Enforcement

It is unlikely that **911, dispatch,** or **law enforcement officers, including police investigators,** will screen for depression. However, if an individual is presenting with expressed suicidal thoughts and intent of harming him/herself, it will affect the immediate response. Imminent threat of self-harm (with the means available and accessed and expressed intent) may require an additional medical response along with law enforcement. **Law enforcement** officers may also request medical transport to a medical or mental health facility for someone who is imminently dangerous or has already acted upon the self-harm intent; and as previously discussed, suicidal thoughts and/or intent to self-harm increase the risk of danger to victims in IPV cases.

Depression Screening/Assessment: Justice System

Corrections officers may screen for depression if they notice that an inmate is spending a great deal of time lying in bed, crying, not sleeping, not eating, and/or talking about harming or killing him/herself. In this case, they should request an evaluation and assessment by jail medical staff. They may also prompt the inmate to request a mental health evaluation by the jail medical staff.

Pretrial and probation officers may also screen for depression if they notice that the perpetrator has a significant weight change (e.g., weight loss without dieting), does not seem to have much energy, expresses hopelessness about the future, cries and appears sad, or expresses thoughts of killing or harming him/herself. This not only puts their client at risk (self-inflicted injuries or death), but when there is IPV, it may mean the victim is in more danger as well. They should refer **and require** the individual to receive a mental health assessment for depression and comply with recommended treatment. They may include this treatment and monitored follow-up as part of sentencing or release requirements.

Both **prosecution** and **defense teams** want to know about mental health conditions, including depression. The **defense team** staff may conduct a screen for depression and may request an additional assessment to help determine the severity of the depression. They are interested in whether depression may have affected the behavior of their client or may impact their client's ability to work with defense counsel and/or comply with court-ordered sanctions. Additionally, they may request an assessment for depression by a community provider or expert. The community provider or expert may conduct additional testing through the use of trustworthy tools (valid and reliable) that specifically test for depression. After determining that depression is a problem, the **defense team** may request court-

ordered treatment and monitoring sometimes in lieu of jail time when depression is determined to be an element of the crime. They may also determine their client meets criteria to be seen in **a mental health court**. **Prosecution** will also consider mental health issues. However, they are interested in how the depression affects the crime for which the individual was arrested. **Victim advocates** working with prosecution will want to know if depression on the part of the perpetrator poses an additional risk to the victim. When it is determined that the accused has committed the crime, prosecution may consider the information from defense to determine appropriate actions and sanctions. However, it is important to remember that an IPV perpetrator may also be depressed, but depression does not cause IPV. In this case, additional mental health treatment may be recommended to stabilize the perpetrator's mental status and improve response to IPV offender intervention.

Specialty court staff (alcohol/drug court, mental health court, and VTCs) should all be able to screen for depression. If a mental health professional is on staff, that individual should also be able to assess the additional elements related to depression. Whether or not someone is depressed (or has some other mental health problem) has to be established before an individual is even eligible to be seen in a mental health court. The **judge** may want to include specific court sanctions that address the depression in addition to other SUD or mental health issues identified.

Depression Screening/Assessment: Community Programs

Community health care settings and **VA** and **military medical settings** can provide screening and assessment for depression. It is in these settings where a full assessment for depression will take place. Primary care providers often see depression in their settings. They are concerned about depression because it has a negative health impact and may present as a medical problem (especially when the patient has lost weight, is not sleeping, and has no energy). Depression may be treated in a primary care setting or the person can be referred to a **mental health** setting. Depression is often co-occurring with substance misuse/abuse, especially for veterans and service members around periods of deployment. Ongoing substance abuse can worsen depression, just as depression can worsen ongoing substance abuse. Most SUD programs provide both screening and assessment for depression. They may also provide ongoing treatment and follow-up for depression along with substance abuse treatment.

Offender intervention program staff should be able to screen for depression. If staff members are also mental health professionals, they can conduct a full depression assessment. Untreated depression is a problem when the depression interferes with the perpetrator's ability to respond to the treatment and may also increase the danger to the victim if the perpetrator feels hopeless and thinks or intends to kill himself/herself. Offender intervention program staff will want to provide or refer the individual for specific mental health treatment to address the depression in addition to the offender intervention program. They will want to also monitor the individual's level of depression and ask about any suicidal thinking or intent. They should have protocols in place to respond to imminent risk when a participant expresses intent to harm himself/herself or others.

INTERVENTION

To properly intervene, thorough and appropriate assessments are needed to determine the context of the IPV, the existence of any co-occurring conditions, and the risk and danger present for the victim as discussed in other sections of this document. Service members returning from deployments to Iraq and Afghanistan, military veterans from other wars/conflicts, and those who have experienced other military-related traumatic events may have a range of co-occurring problems, both physical and psychological, that can increase the frequency and intensity of IPV as well as increase risk and danger. Certain behaviors may also overlap. While these co-occurring conditions may contribute to IPV, **they do not cause** IPV. Professionals who intervene with military and veteran families need to be able to recognize if any of these conditions exist and know how to intervene safely and effectively or have protocols in place for appropriate referrals.

Intervention for one problem will not address all the problems. Appropriate and adequate assessment and tailored specific interventions are needed for each of these co-occurring problems and should be provided by a person with specific subject matter expertise. No one provider has subject matter expertise in IPV and all co-occurring conditions. Multiple interventions may need to occur concurrently. When IPV is present along with any or all these conditions, it is especially important to direct the military service member or veteran to additional resources that address the IPV. The adult victim, who is sometimes also the primary caregiver for a disabled veteran, will need victim advocacy and specialized intervention around safety and safety planning.

The intervention provided by most points of intervention will not be different for military personnel and veterans IPV perpetrators than it is for those with no military connection or history. However, there are some specific considerations that need to be highlighted.

Considerations for Law Enforcement

The Praxis International Blueprint for Safety, Training Memo, Justice-Involved Military Personnel and Veterans (Tinney & Strand, 2010) addresses specific considerations for **law enforcement** intervention with military personnel and veterans as described in the following excerpt:

> Law enforcement officials responding to a domestic dispute involving a military member or veteran should always be alert to the possibility that they may have weapons and be extremely proficient in the use of those weapons. Weapons in the hands of disturbed individuals generally increase the risk to the responding officer and/or other individuals in the area. Not all mentally or emotionally ill people are dangerous, while some may represent danger only under certain circumstances or conditions. The following factors increase danger:
>
> - Availability of weapons
> - Statements by the subject that suggest they are prepared to commit a violent/dangerous act
> - A personal history that reflects prior violence under similar or related circumstances
> - Lack of control of emotions such as rage, anger, fright, or agitation
> - Volatility of the environment
>
> It is important for law enforcement to keep the following information in mind when responding to calls involving military service members and veterans:

- The vast majority of military personnel and veterans are not a risk to law enforcement or the general public. However, many people with military backgrounds and experience do have personal firearms. The presence of weapons can increase risk for first responders.
- Most military personnel have a healthy respect for and understand authority, even in a stressful situation. This may be advantageous for law enforcement intervening with a service member or veteran and may assist in making a connection based on mutual respect.
- During initial and ongoing training, many military personnel are trained in the use of lethal force and the specific circumstances in which it is appropriate.
- Military personnel are also trained on who the enemy is and isn't. Most military personnel and veterans would not view law enforcement personnel as the enemy unless they are experiencing combat-related mental health issues.
- All military personnel go through rigorous training and indoctrination on proper use of force and escalation of force along with rules of war. For most, this training decreases the likelihood of inappropriate use of force. Some veterans who are emotionally disturbed may pose a greater risk due to the additional training they received in the military.

Considerations for the Criminal Justice System and Community-Based programs

There are also specific considerations for **courts** and **community-based offender intervention programs**. It is not always clear whether military personnel and veterans were IPV perpetrators before deployment or whether combat experiences contributed to the behavior. Therefore, an effective response to this population would be a coordinated community approach that includes:

- Screening for military and combat experience by appropriate responding agencies
- Assessment for possible co-occurring conditions by appropriate mental health providers
- Adoption of appropriate risk assessment protocols in each responding agency
- A range of court-ordered sanctions that support perpetrators in ending violent behavior while carefully monitoring compliance with court orders to ensure victim safety
- IPV intervention services that understand and address the complex issues of these perpetrators

There are different levels of accountability when responding to IPV cases. The perpetrator is accountable for choosing to use violence with his/her intimate partner and should be held accountable by all parts of the system. Educational or therapeutic programs for IPV perpetrators were introduced in the 1980s and are available in many jurisdictions to promote cessation of violence and adoption of alternative non-violent behaviors. There are different approaches to this type of programming, but every offender intervention program should hold the perpetrator accountable for ending the violence, and at the same time, the program itself should be accountable to the court, the victim, and all community partners.

Community programs, including offender intervention programs, will face challenges as increasing numbers of military personnel and veterans are mandated for services. While specific offender

intervention programming for military personnel and veterans may be available in some locations, this will not be available in most communities.

Offender programs, **VA facilities**, **military medical treatment facilities** (MTFs), and community **health** and **mental health** agencies should work with perpetrators as part of a community effort to confront and eliminate perpetrators' use of violence and not become their advocates. This commitment is necessary because offender programs and health and mental health agencies that are not tied to a much larger community system of controls and accountability are often used by perpetrators, whether military-related or not, to get back into their homes, to win court and custody battles, to avoid criminal and civil court sanctions and proceedings, and to convince their partners that they are changing, even when there is no true altering of the power dynamics in the relationship.

Counselors and group facilitators are continually dealing with participants who bring up their lived experiences -- in part to justify their behavior. Military personnel and veterans may attribute all their violent and abusive behaviors to recent combat deployments or to symptoms of co-occurring conditions such as PTSD, TBI, etc. Offender programs have different approaches in their work with male IPV perpetrators. Cognitive-behavioral models are the most widely used approach focusing less on psychological assessments and therapy and more on how power relationships and entitlement are reflected in individuals and families. The philosophical core of this approach is the belief that men who engage in IPV with coercive control use physical and sexual violence and other abusive tactics to dominate their partners. These perpetrators use violence to stop arguments, to control their activities, and to punish them for non-compliance.

Anger management classes are used in some programs despite the criticism of their effectiveness. Most offender programs question whether teaching an IPV perpetrator to control his anger will stop the violence if the intent of his behavior is to control or dominate a partner. Skill-building techniques like "time outs" and "cool downs" may help men with poor impulse control and aggression but will ultimately be ineffective if the perpetrator wants to maintain his dominance over his partner. Anger has also received a considerable amount of attention in active duty military and veterans' groups because of the association between the hyperarousal symptom cluster of PTSD, anger, and aggression (Bell & Orcutt, 2009; Jakupcak, et al., 2007; Taft, Vogt, Marshall, Panuzio, & Niles, 2007). Anger management classes are often a routine part of PTSD treatment. Treatment providers and courts may recommend PTSD and anger management treatment for military personnel and veterans who are IPV perpetrators confusing IPV tactics with PTSD symptoms. A careful and thorough assessment should be conducted for both, and concurrent treatment recommended if both are present. Most offender and battered women's programs advocate against marriage counseling as an alternative to IPV offender groups. Unless the violence, coercion, and threats have ended, a victim typically will not feel safe in marriage counseling.

The reality is that some couples *do* stay together. Practitioners should follow clear guidelines and agencies should adopt policies that state that marriage counseling should be provided only under the following circumstances:

- A practitioner is convinced that the violence, coercion, threats, and intimidation have ended.
- The perpetrator has completed a reputable offender program that focuses on changing sexist beliefs and attitudes about mans' right to dominate women.
- The victim has worked with a victim advocate and has a safety plan.
- The victim feels safe.
- The practitioner has discussed safety issues with the victim.

An added element of concern is when the spouse/partner is the caregiver for a disabled service member or veteran. Veterans often experience the partner's caregiving as much needed support, but sometimes as a threatening reminder of their own diminished capacity. These tensions, paired with minimal information about PTSD, can leave some partners feeling helpless, incompetent, and frustrated, and some veterans feeling belittled, controlled, and thereby triggered. An activity usually done out of love and concern may be experienced with fear and anxiety if their caregiving results in their victimization (Gerlock, Grimesey, & Sayre, 2014).

Considerations for Military/Veteran-Specific Offender Intervention Programs

There has been much discussion nationally about the need for military- or veteran-specific IPV offender intervention programs. The reality is that many jurisdictions will not be able to support community-based offender intervention programs specific to military personnel and veterans simply because they will not have enough participants. In addition, culturally-specific groups have both advantages and disadvantages that must be considered. Culturally-specific groups can enhance facilitator–group member connection by removing cultural barriers between them; remove possible resistance from group members to discussing subjects in front of other cultural groups; and facilitate greater openness among group members more quickly due to shared cultural norms.

While culturally-specific programs may have advantages for some perpetrators, there is limited research in this area. Outcome studies of conventional offender treatment programs versus culturally-focused groups found that the recidivism rates are essentially the same, and noted both advantages and risks with culturally-specific groups. (Gondolf & Williams, 2001; Gondolf E. W., 2011)

The advantages of culturally-specific offender intervention programs are:

- Some perpetrators will be more amenable to the group process if they believe that they can freely talk about aspects of their everyday life experiences in a non-threatening environment.
- Counselors and facilitators from a similar cultural group can challenge a perpetrator's rationalization for his use of IPV based on religion, racial oppression, sexual orientation, combat exposure, etc.
- Offenders may choose to volunteer to participate in an offender program if they know they will be in a group of their peers.

The risks are:

- Culturally-specific groups can engage in "group think" when a participant focuses on a cultural explanation for his behavior or beliefs. For example, a group that includes all military personnel and veterans may reinforce the idea that their IPV perpetration is caused by combat experience, PTSD, or other combat-related co-occurring conditions.
- In any offender group, collusion can occur. If both counselors and facilitators are not from the culturally-specific group, they may feel that they cannot challenge what a perpetrator is saying because they haven't had similar experiences.
- Resources for offender programs are already limited, so adding culturally-specific programs might be an impediment and take limited community resources from battered women's programs.

The decision to start a group for military personnel and veterans should not be made in a vacuum. Offender programs should work with battered women's programs, the courts, the VA, and other

providers to explore this and other potential unintended consequences of starting military- and veteran-specific groups such as, does the veterans' group provide a subtle message to the victim to forgive her/his abusive partner because of his combat experiences? Does having a culturally-specific program imply that the court should treat or is treating IPV cases involving military personnel and veterans differently? More research needs to be done to guide the addition of military-and veteran-specific groups in offender programs.

VA National IPV Assistance Program

Recognizing the risks that IPV poses to the veteran population and their partners and families, and the degree to which IPV is a co-morbid factor related to other issues of concern including suicide, homicide, homelessness and poverty, the VA Domestic Violence/Intimate Partner Task Force was chartered in May 2012. This Task Force produced the *Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program (2013),* and the program was officially launched in January, 2014 through the Office of Patient Care Services, Care Management and Social Work. The implementation plan provided the vision, mission and framework for national implementation of the VHA Intimate Partner Violence Assistance Program, based on 14 recommendations for establishing an integrated and comprehensive array of programs and services to address the needs of veterans, their partners, and VA employees who are impacted by IPV. In general, the recommendations fall into five strategic domains: raising awareness/training; community engagement; screening and services for those who experience IPV; identification and services for Veterans who use IPV; and services for VA employees impacted by IPV. Since the initial inception of the program, six program demonstration sites have completed initial implementation, and this program continues to expand due to national program efforts and the genuine concern and dedication of VA staff and leadership at many medical centers. However, as this is currently an unfunded program that lacks legislative backing, full national coverage and consistent programming remain contingent on the willingness and ability of individual medical centers to dedicate staff time, space and resources from their existing overstretched budgets. To date, no legislation exists to mandate IPV programming or allocation of staffing to address these identified needs, and no funding has been allocated to ensure that each VA Medical Center is able to designate an on-site Intimate Partner Violence Assistance Program (IPVAP) Coordinator to carry out the task force recommendations.

A pivotal component of the Program is the establishment of the IPVAP Coordinator positions. These people are licensed independent mental health providers. When the Program is rolled out nationally, every VA medical center will appoint an IPVAP Coordinator to assist both veterans who are victims and perpetrators. If a family member of a veteran who is a perpetrator requires assistance, the IPVAP Coordinator will provide the family member with a warm hand-off to community-based domestic violence resources.

Family members or intimate partners of veterans who are not veterans themselves are not eligible for services at VA medical centers and will not be directly covered under the IPV Assistance Program. Community-based Vet Centers do see family members, but personnel in these centers do not generally have specific expertise in dealing with IPV. Therefore, most veterans and their families experiencing IPV should seek help from domestic violence programs in the community where they live.

Offender programs typically have a process for contacting victims to obtain a history of the violence and offer support and information about the content of the program. Some offender programs that are connected to battered women's programs, or have advocates on staff, provide an initial support/information group for the partners of participants. Caution is exercised regarding information

divulged by partners until safety planning has been explored and the propriety of using the information is determined.

Information sharing can be a challenge when intervening with military personnel and veterans in community-based programs. VA facilities and military medical treatment facilities may be poorly integrated into larger community services and responses, thus further isolating victims. Certain policies and rules of behavior that bind providers in these settings may be known only to them and not to victims or other community providers. Written authorization to contact all providers involved with the service member, veteran, or family member will be critical in holding offenders accountable and ensuring victim safety. The veteran, if an IPV perpetrator, is the patient and has the relationship with the treatment providers who cannot even talk with the partner/victim without a release of information; IPV perpetrators can use this confidentiality to further cut off and isolate the victim and target medical professionals who try to help. Healthcare professionals must learn how to respond safely and appropriately within DoD and VA guidelines.

Community-based programs must address ways to overcome these obstacles for partner contact when an offender intervention program is being offered within the military or VA systems. Partner/victim contact is extremely important in order to provide information about the IPV perpetrator's response to treatment and to alert the partner/victim if any change in danger is detected during offender intervention. Several things should be considered in handling partner/victim contact: 1) Having a systematic way of obtaining release of information authorization for partners/victims before intervention commences; 2) Implementing routine procedures to ensure safety within the military, clinic, or health care setting for partners/victims when contact is made; and, 3) Respecting a partner/victim's request NOT to be contacted. If a situation arises in which the treatment provider believes there is an imminent threat to the safety of a partner/victim (or other involved party), the duty to warn should be handled as it is in other imminently dangerous situations within the treatment setting.

PTSD and other combat-related mental health issues are not an excuse for violent and controlling behavior. Military personnel and veteran IPV offenders should be held accountable for their behavior when they violate the law. However, it is important to be sensitive to the fact that people who have been in a combat zone are often changed forever by that experience, as are their families. We can't totally understand what they have been through even if they do talk to us about it, but we can be there to set appropriate limits and provide support and intervention that is needed to keep our military personnel, veterans, their families, and our communities safe.

Tips for Intervening with Military Personnel and Veterans

Here are some tips for community-based programs intervening with military personnel and veterans who are IPV perpetrators:

- ***Collaborate with military installations:*** If there is a military installation nearby, efforts should be made to enhance the military/civilian collaboration in responding to IPV and intervening with IPV offenders who are military personnel. This collaboration should include development of memoranda of understanding between the installation and civilian law enforcement, civilian courts, and community-based domestic violence and offender intervention programs and the military Family Advocacy Program (FAP). FAP provides prevention efforts, early identification and intervention, support for victims, and treatment for offenders. FAP is responsible for ensuring victim safety planning and bringing victim safety concerns to command and law enforcement agencies, providing support and advocacy services, as well as ensuring that

offenders receive appropriate intervention and treatment services. FAP services are available to active duty service members, their partners, and children.

- ***Collaborate with VA facilities:*** Within the VA, IPVAP Coordinators will be key contacts as the IPV Assistance Program is fully-implemented and Coordinators are appointed in each VA Medical Center. For justice-involved veterans, VJO specialists can be an important ally in holding offenders accountable. They are the liaison between the veteran, justice system, and VA medical center. While the VJO specialist will likely have the expertise in understanding and responding to PTSD, TBI, and other co-occurring conditions, they may or may not have the expertise in understanding and responding to IPV.
- ***Use institutional powers effectively:*** Communities must use their institutional powers to hold IPV perpetrators accountable for their behavior and make a commitment to place increasingly harsher penalties and sanctions on those who continue to abuse their partners. They need to insist that military personnel and veterans are held as accountable as offenders with no military experience, and that appropriate sanctions are instituted. To conduct counseling groups or classes without having first insisted on services for battered women and on police and court reforms is not only short sighted, but in the long run, also dangerous. It is important that offender programs actively participate in whatever version of a CCR that exists locally to talk through the safety implications of working with military personnel and veterans who have used IPV.

CONCLUSION AND RECOMMENDATIONS

This document addresses the roles and responsibilities of various points of intervention in screening and assessing for and intervening in IPV cases with active duty military personnel and veterans when there are also co-occurring problems. Responding to the combined impact of multiple co-occurring problems can be a challenge because one problem can affect another, and a change in any one problem can quickly impact the overall dangerousness of the IPV situation. Not all points of intervention have the same responsibilities for screening, assessment, and intervention. Some points of intervention will only conduct quick screens, thus providing information that will inform additional actions taken at other points. Some points of intervention will carry the responsibility for more thorough assessments, some of which will also provide the intervention for the identified problem(s). All points of intervention carry the responsibility for screening for IPV and assessing for immediate risk and danger. Some settings will require multiple screens/assessments over time.

An additional challenge is the need for multiple responses from multiple systems. Dealing with multiple community systems is difficult under any circumstances but may be daunting for military and veteran families who are trying to respond to both community/civilian as well as military/veteran systems. Therefore, coordination and collaboration with military installations and programs and VA facilities is critical to ensuring a seamless response to IPV involving military and veteran IPV perpetrators. Failure to identify IPV and other co-occurring problems for service members and veterans poses an additional problem that places individuals and communities at risk. It is essential that each part of the system understand the roles and responsibilities at each point of intervention to support families of service members and veterans and to keep communities safe.

Recommendations

It is recommended that points of intervention conduct the following screening and assessment for IPV and co-occurring conditions.

All Points of Intervention: Military and Veteran Specific Information

- Incorporate awareness of, and sensitivity to, military and veteran culture into training for all interveners.
- Screen routinely for military experience, war-zone deployments, and combat experience.
- Screen for co-occurring conditions such as PTSD, TBI, substance abuse, and depression.
- Have protocols in place for more in-depth assessment and/or refer when there is a positive screen.
- Develop collaborative relationships with military installations and VA facilities, where they exist.
- Create memoranda of understanding to address information sharing between military, veteran, and community-based agencies/programs.

Best Practice for All IPV Cases: Law Enforcement and Justice System

- Participate in a coordinated community approach to responding to IPV.
- Obtain demographic information on IPV offenders.
- Screen routinely for a criminal and/or court history.
- Screen routinely for a protection order history.
- Screen routinely for presence of and access to weapons.

- Screen for risk factors for re-offense in IPV cases.
- Assess for and monitor ongoing risk/danger/lethality in IPV cases.
- Screen routinely for a history of IPV victimization and perpetration and have protocols in place for more in-depth assessment and/or refer when there is a positive screen.
- Conduct a contextual analysis to determine the larger context in which the IPV is embedded to inform ongoing risk and danger assessment and safety planning, as well as decisions about appropriate intervention.
- Screen every IPV perpetrator for:
    - Depression and suicidal/homicidal thinking and intent
    - Substance abuse
    - PTSD and TBI
- Have protocols in place for more in-depth assessment and/or refer when there is a positive screen.
- Assess for immediate danger and have protocols in place to respond to situations of imminent threat.

Best Practice in All IPV Cases: Community Programs (including DoD and VA facilities)

- Participate in a coordinated community approach to responding to IPV.
- Screen for abuse history, both victimization and perpetration, and have protocols in place for more in-depth assessment and/or referral when there is a positive screen.
- Conduct a contextual analysis to determine the larger context in which the IPV is embedded to inform ongoing risk and danger assessment and safety planning, as well as decisions about appropriate intervention.
- Identify the types and patterns of abuse and abusive tactics.
- Determine the frequency and severity of the IPV.
- Assess for and monitor ongoing risk/danger/lethality in all IPV cases.
- Assess for immediate danger and have protocols in place to respond to situations of imminent threat.
- Provide in-depth assessments for mental health and substance abuse issues when there is a positive screen for IPV victimization and/or perpetration or refer to a qualified provider when appropriate.
- Provide in-depth assessments for deployment/combat-related PTSD, TBI, and depression in military personnel and veterans when there is a positive screen or refer to a qualified provider when appropriate.

Best Practice for Intervention: Community Programs (including DoD and VA Facilities)

- Incorporate awareness of, and sensitivity to, military and veteran culture into training and programming for all interveners.
- Participate in a coordinated community approach to responding to IPV.

- Develop collaborative relationships with military installations and VA facilities.
- Create memoranda of understanding to address information sharing between military, veteran, and community-based agencies/programs.
- Assess every IPV perpetrator for depression and suicidal/homicidal thinking and intent and have protocols in place for more in-depth assessment and/or referral as needed.
- Assess every IPV perpetrator for co-occurring conditions such as PTSD, TBI, and substance abuse and have protocols in place for more in-depth assessment and/or referral as needed.
- Conduct a contextual analysis to determine the larger context in which the IPV is embedded to inform ongoing risk and danger assessment and safety planning, as well as decisions about appropriate intervention.
- Assess for immediate and ongoing danger and have protocols in place to respond to situations of imminent threat.
- Provide specific, concurrent interventions for each co-occurring problem and ensure that providers have specific subject matter expertise in the areas being addressed.
- Provide specific offender intervention programs to confront and eliminate perpetrators' use of violence in intimate relationships.
- Involve battered women's programs, the courts, the military, the VA, and other providers to explore developing military and veteran-specific IPV offender intervention programs and consider potential unintended consequences.
- Develop and implement clear policies and guidelines for handling information divulged by partners and err on the side of caution when deciding about the propriety of using the information.
- Implement and follow clear policies and guidelines for use of couples/marriage counseling in IPV cases to ensure victim safety.

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Appendix A: CIVILIAN-MILITARY-VETERAN COORDINATED COMMUNITY RESPONSE

United States Marine Corps Project

In the early 1990's, the United States Marine Corps (USMC) partnered with the Domestic Abuse Intervention Project (DAIP) in Duluth, Minnesota to develop and implement a Coordinated Community Response (CCR) to domestic violence throughout the USMC. This project was initiated in response to an increased number of murders and brutal assaults of women by their military partners who returned from Operation Desert Storm.

Over a period of six years, protocols and operating procedures were designed to guide the response of all Marines to incidents of IPV. Providing strong victim advocacy became a key component of the intervention response designed to identify the context of violence, account for victim safety, and provide measures to hold offenders accountable. The development of a comprehensive assessment tool to identify IPV and tactics of coercive control was key to making the context of violence visible and recommending an appropriate response to contain and control the perpetrator of the violence.

The redesigned intervention model shifted the focus from a medical/psychological intervention to include a criminal justice response. Each installation developed a base order to coordinate the response to IPV, and Memoranda of Understanding (MOU) were created between USMC installations, civilian courts, and law enforcement. The project became one of the most aggressive and comprehensive responses to IPV put forth by the military, and most uniquely, in collaboration with a civilian domestic violence agency.

Washington State Combined Batterer Intervention Program

In 1995, the Madigan Army Medical Center (MAMC) and American Lake VA Medical Center entered into the first sharing agreement ever to combine resources in the delivery of a state certified batterer intervention program (BIP). This program was one component of a CCR that demonstrated collaboration between Madigan and American Lake personnel to offer jointly domestic violence rehabilitation to active duty service members and military veterans. Active duty Army, Air Force, Coast Guard personnel, and military veterans were potentially eligible for the program. Although this program was not a comprehensive CCR, it is an early example of collaboration between the civilian, military, and VA systems to provide a critical component of a CCR.

The rehabilitation program was a Washington State Domestic Violence certified program and met all requirements mandated by law (Washington Administrative Code 388-60). The program consisted of four phases: assessment, orientation, rehabilitation, and maintenance. Specially trained MAMC Family Advocacy Program (FAP) and American Lake VA Medical Center staff completed initial domestic violence assessments. After an initial assessment and intake, service members and veterans entered a four-week orientation class, followed by a minimum of 26 weekly group sessions, and a minimum of six months of monthly maintenance sessions. Each phase required successful completion of transition criteria. A collateral interview with either the victim or a community contact was conducted before the participant moved into the maintenance phase, to verify that transition criteria were met (e.g., stopping all physical violence and psychological abuse, remaining drug and alcohol free, and halting all victim-blaming behaviors).

Ongoing collaborative relationships were established with county probation officers and state parole officers to review the progress of the BIP participants, and to make adjustments in probation/parole or intervention strategies to ensure accountability of the offender. Non-compliance with program expectations was immediately reported to probation/parole.

During a six-month period, 62 military veterans and military service members volunteered to be followed for their course of rehabilitation that spanned from one to two years. These men were compared on a number of variables. On the variables compared, there were **no** significant differences between military service members and military veterans based on completion and non-completion of the program.

BWJP Demonstration Project

BWJP conducted civilian-military CCR demonstration projects from 2004 to 2008 through a grant from the Department of Justice Office on Violence Against Women. The demonstration sites were Ft. Campbell, Kentucky, the Naval Air Station, Jacksonville, Florida, and Naval Station, Mayport, Florida.

The goal of this project was to create guidelines for coordinating the response of civilian and military agencies to IPV cases involving military personnel that:

- Enhanced victim safety and autonomy
- Effectively held perpetrators accountable for ending their violence
- Provided safety and support to children exposed to violence in these families

Collaborating for Safety: Coordinating the Military and Civilian Response to Domestic Violence – Elements and Tools (Sadusky, 2010) is the report from the demonstration projects. It provides information about the military context and environment and identifies potential problem areas in bringing military and civilian communities together to address IPV. It also provides tools for developing and maintaining a civilian-military CCR. The guide's primary focus is how to create a sense of common mission and purpose among the participants.

The demonstration projects clearly identified that building a civilian-military CCR requires attention to how distinctive aspects of the military context and environment affect the response to IPV cases and the CCR design process. To develop an effective civilian-military CCR, organizers must be attentive to the following considerations:

- **Lines of Authority:** Civilian partners have to learn more about how the military and each Service branch work. Civilian partners must be attentive to chain of command, rank, protocol, and formality in building relationships essential for the CCR. Military partners must understand that civilian lines of authority and decision making are often multifaceted, involve elected officials, and may involve reporting to and taking direction from a unit of government, such as the city council or county board of supervisors.

- **Core Values and Military Service:** Each military Service has a set of core values that has to do with honesty and honor, etc. There is a universal expectation that each service member will act in ways to uphold these values. Civilian partners must understand this key feature of military culture. Core values provide a foundation and rationale for military attention to IPV.

Intervening, protecting, and collaborating with civilian partners are in keeping with core values. Acts of IPV are not in keeping with core values.

- **Movement and Turnover:** Military installations experience high levels of personnel movement and turnover. Those involved in establishing and supporting the CCR one year may not be there the next. The CCR must consider ways to ensure that its principles and practices will be maintained despite frequent change of personnel, both military and civilian.

- **IPV Resources:** Civilian partners need to understand the military response to IPV, who the key players are on the installation, and their roles. Military partners need to understand the civilian response to IPV, who the key players are in the community, and their roles. MOUs should be in place to define the relationships between different agencies to ensure a seamless transition for military-related IPV victims.

- **Confidentiality:** Civilian partners need to understand the close relationship between a person's work and private life in the military and how it affects reporting. Civilian partners need to understand the limits to confidentiality in the military system. Military partners need to understand confidentiality in the civilian system. Issues related to reporting and confidentiality can be key points of disagreement and debate between civilian and military interveners.

- **Defense Task Force on Domestic Violence:** Recommendations made by the Task Force and subsequent implementation by the Department of Defense (DoD) set a clear expectation for all military departments and commands to promote a CCR, both within military agencies and between military and civilian interveners. This expectation is threaded throughout DoD policies and instructions.

- **Jurisdiction:** Developing a joint CCR requires understanding where and how civilian authorities have or might have jurisdiction on the military installation in responding to IPV. Jurisdictional issues must be clearly defined and understood by both the military and civilian partners. MOUs can help to clarify and institutionalize the roles of military and civilian interveners.

The demonstration projects also identified the following challenges that must be addressed when developing a civilian-military CCR:

- Setting a tone of trust and partnership from the beginning
- Reaching a common understanding of the underlying assumptions and framework that will guide the work of the CCR
- Accepting key principles of advocacy that emerged from the battered women's movement such as victim and survivor autonomy and confidentiality
- Facilitating a willingness to genuinely participate and work to maintain the CCR

Appendix B: MILITARY SERVICE SCREENING TOOL

Date_____

- Have you ever served on active duty in the Army, Navy, Air Force, Marines or Coast Guard or in the National Guard or Reserves? If yes, ask:
    - Which service?
    - When?
    - What was your job in the service?
    - Did you receive specialized training? If yes, ask:
        - What type of training?
- Have you ever deployed to a war zone? If yes, ask:
    - How many times?
    - Where?
    - When?
- Do you have combat experience? If yes, ask:
    - Where?
    - When?

Appendix C: INTIMATE PARTNER VIOLENCE ASSESSMENT TOOL

Date_____

Demographic Information

Name_____ Date of birth_____ Home phone _____

Cell phone _____

Address _____County _____City_____
State ____Zip_____

Ethnicity or race _____

Were you ever in the U.S. military? ☐ Yes ☐ No
Branch _____ (Army, Navy, Air Force, Marine Corps, Coast Guard)
Component _____ (Active Duty, Reserves, National Guard)
Date discharged _____ Type of Discharge _____

Have you ever served in a war zone? ☐ Yes ☐ No
When, where, and for how long? _____
How many times were you deployed? _____

Do you have combat experience? ☐Yes ☐ No
If yes, when, where, and for how long? _____

_____

Have you experienced or witnessed trauma (combat or non-combat; military or civilian)? If yes, when and what? _____

What was your job in the service? _____

Did you receive specialized training? ☐ Yes ☐ No

If yes, what type of training? _____

Employed? ☐ Yes ☐ No Employer _____

Employer address _____ Work phone_____
Email address _____

How long have you worked there? _____
If not employed, when was the last time you worked? _____

What kind of job was it? _____

What other jobs have you had? _____
What is the longest job you've ever had? _____

What are your income sources? _____

Spouse/Partner _____ Date of birth _____
(or former spouse/partner—person with whom you **were violent**)

If victim other than partner, what relationship to you? _____

Address _____ City _____ State_____
Zip_____

Ethnicity or race_____

Home phone _____Work phone_____ Cell phone _____

Email address _____

How many children currently live with you? _____ What are their ages and sexes?

_____

Are these your biological children? ☐ Yes ☐ No If no, what is their relationship to you?

_____

Do you have children that live elsewhere? ☐ Yes ☐ No If yes, how many _____

What are their ages and genders? _____

Where do they live? _____

Are these your biological children? ☐ Yes ☐ No If no, what is their relationship to you?

_____

How often do you visit with them? (Explore visitation issues and child support.) _____

_____

_____

Law Enforcement/Court Involvement

Have the police (civilian or military) contacted you because of an incident (violent or non-violent) with the above-named person? ☐ Yes ☐ No How many times?

_____

Were you arrested for the most recent incident? ☐ Yes ☐ No Were you given a ticket? ☐ Yes ☐ No
Did you spend time in jail or military detention facility? ☐ Yes ☐ No

Have you been arrested and/or charged in the past for a violent crime(s)? ☐ Yes ☐ No
What crime(s)? _____
Where and when? _____
Conviction(s)? _____
Military discipline (court martial or non-judicial punishment)? _____

Are you on probation/parole/community supervision? ☐ Yes ☐ No If yes, for how long (in months)?

_____
Who is your probation/parole/community supervision officer? _____
Officer's contact information _____

What are your conditions? ☐ Treatment ☐ Stay away from victim ☐ Fine
☐ Abstain from alcohol/drugs ☐ Chemical dependency/alcohol/mental health evaluation ☐ Domestic violence offender intervention treatment

☐ No same or similar offenses ☐ Firearms prohibition ☐ Community service ☐ Restitution

List any other conditions: _____

Protection Orders

Is there an order of protection against you? **(civilian, criminal, military)** ☐ Yes ☐ No

Date of order_____ Length of order _____Judge_____

Why do you currently have an order against you? _____

_____

<u>Conditions of order</u>

☐ No contact ☐ Peaceful contact ☐ Excluded from residence
☐ Stay away from: _____ ☐ Firearms prohibition ☐ Contact only for visitation

☐ Use the Visitation Center ☐ Supervised visitation ☐ Fathers' group ☐ No further abuse

☐ Treatment ☐ Chemical dependency evaluation Where? _____

List any other conditions: _____

Have you had previous orders against you? ☐Yes ☐No
When and where? _____

_____

_____

List the reasons for other orders: _____

_____

_____

Have you ever violated an order? ☐Yes ☐No Please describe where and when, the reason for the order(s), and the consequences for the violation(s):

_____

_____

_____

_____

Have you ever been to counseling for violent/abusive behavior? ☐Yes ☐No
When and where? _____

_____

Describe in detail the counseling you received: _____

_____

_____

Alcohol and Drug Use/Abuse

What is your current alcohol/drug consumption?
# of drinks containing one ounce of hard liquor per week: _____
# of beers (12 ounces) consumed per week: _____
# of glasses of table wine (4 ounces) per week: _____

Type of drugs and frequency (i.e., marijuana, cocaine, crack, opiates, inhalants, over-the-counter drugs, and prescription drugs, etc.): _____

_____

_____

Have you used alcohol and/or drugs in the past?
# of drinks containing one ounce of hard liquor per week: _____
# of beers (12 ounces) consumed per week: _____
# of glasses of table wine (4 ounces) per week: _____

Type of drugs and frequency (i.e., marijuana, cocaine, crack, opiates, inhalants, over-the-counter drugs, and prescription drugs, etc.): _____

_____

_____

Have you had substance-related arrests? ☐ Yes ☐ No Describe in detail the substance used, the charge, and the case disposition: _____

_____

_____

What problems has your use of alcohol and/or drugs created in your life?

_____

_____

_____

Do you think your current use of alcohol and/or drugs is excessive? ☐ Yes ☐ No
Have you ever had an alcohol assessment? ☐ Yes ☐
When and where? _____

Have you ever had a chemical dependency assessment for drugs? ☐ Yes ☐ No
When and where? _____

Have you ever been to alcohol treatment? ☐ Yes ☐ No
What type of treatment, when, and where? _____

_____

Did you complete that treatment? ☐ Yes ☐ No When? _____

Have you ever been to drug treatment? ☐ Yes ☐ No
What type of treatment, when, and where? _____

_____

Did you complete that treatment? ☐ Yes ☐ No When?_____

Personal History of Violence/Abuse

When you were growing up, where did you hear or witness violence? (for example: home, school, boarding school, foster home, streets, correctional facility, treatment center, etc.)

What violence did you hear or witness when you were growing up?

Describe your parents' relationship when you were growing up:

Do you feel you were abused as a child? ☐ Yes ☐ No If yes, please describe the abuse in detail:

Thinking about when you were a child, did **you** ever use violence against others? ☐ Yes ☐ No
☐ In your family ☐ In your neighborhood ☐ On the street ☐ School ☐ Sports ☐ Gangs
Other places? _____

Please describe in detail any violence you used against others when you were growing up:

Violent/Abusive Actions in Relationships

Current Relationship
General:
How long have you been in a relationship with your current partner? _____

Are you married to your partner? ☐ Yes ☐ No

How many times have you and your partner separated and reunited? _____

Has your partner communicated a desire to permanently end the relationship? ☐ Yes ☐ No

When? _____

How often do you and your partner argue? Please describe your arguments:

Has there been an increase in frequency, severity, or type of violence in recent months?
☐ Yes ☐ No Please describe in detail:

Do you own or have access to any weapons? If yes, list all weapons and where are they kept:

Have you ever threatened your partner with a weapon? If yes, please describe in detail what happened:

Have you ever cleaned a weapon while engaged in a disagreement with your partner? If yes please describe in detail what happened:

Do you have martial arts, military or law enforcement training? If yes, please describe in detail:

How do you express your jealousy?

Has your partner ever tried to get outside help in the past year because of violence/abuse (for example, police, Order for Protection, shelter, counseling)? ☐ Yes ☐ No Please describe help sought:

How many times have the police been called to your/your partner's residence due to your violent/abusive actions? Please describe incidents in detail:

Please describe in detail the first time there was an incident that involved violent/abusive actions toward your partner:

When was the last incident of any kind of violent/abusive actions toward your partner?
Date _____ Please describe the incident in detail:

Have you ever fantasized about killing your partner? If yes, please describe in detail:

Have you ever threatened to kill your partner? If yes, please describe in detail:

Have you ever attempted to kill your partner? If yes, please describe in detail:

Please describe in detail how you feel about your violent/abusive actions toward your partner:

Incident That Brought You to Court:
Please describe in detail your violent/abusive actions toward your partner in the incident which brought you to court:

Please describe in detail any injuries inflicted as a result of your violent/abusive actions toward your partner in the incident that brought you to court and any emergency/medical care your partner required for the injuries:

Please describe in detail any injuries you sustained as a result of your violent/abusive actions toward your partner in the incident that brought you to court and any emergency/medical care required:

Prior Incidents of Violence in Current Relationship:
Please describe in detail your violent/abusive actions toward your partner prior to the incident that brought you to court:

Please describe in detail any injuries inflicted as a result of your violent/abusive actions toward your partner prior to the incident that brought you to court and any emergency/medical care your partner required for the injuries:

Please describe in detail any injuries you have sustained as a result of your violent/abusive actions toward your partner prior to the incident that brought you to court and any emergency/medical care required:

Please describe in detail your worst violent/abusive actions toward your partner, the injuries inflicted as a result of those actions, and any emergency/medical care required by your partner:

Previous Intimate Partner Relationships:
Please describe in detail your violent/abusive actions toward your partner(s) in previous intimate relationships:

Please describe in detail any injuries inflicted as a result of your violent/abusive actions toward your partner(s) in previous intimate relationships and any emergency/medical your previous partner(s) required for the injuries:

Please describe in detail any injuries you have sustained as a result of your violent/abusive actions toward your partner(s) in previous intimate partner relationships and any emergency/medical care your previous partner(s) required:

Please describe in detail your worst violent/abusive actions toward your partner(s) in previous intimate partner relationships, the injuries inflicted as a result of those actions, and any emergency/medical care required by your partner(s):

Other Relationships and Situations:
Please describe in detail the worst violence you have committed in any relationship or situation other than with intimate partners (for example, friends, other family members, children, barroom fights, confrontations with police, etc.):

Please describe in detail any injuries inflicted as a result of the worst violence you have committed in any relationship or situation other than with intimate partners and any emergency/medical care required for the injuries:

Please describe in detail any injuries you have sustained as a result of the worst violence you have committed in any relationship or situation other than with intimate partners and any emergency/medical care required for the injuries:

Please describe in detail your arrests for violent/abusive actions in both intimate partner relationships and other relationships and situations:

Medical History

Do you have any health problems? If yes, please describe in detail: _____

_____

_____

Are you taking medication(s)? ☐ Yes ☐ No If yes, list all medication(s) and who is prescribing them: _____

_____

Have you ever had a head injury? ☐ Yes ☐ No
When and where? _____

_____

Have you ever been knocked out or in a coma? If so, how long? _____

_____

Have you ever been diagnosed with a traumatic brain injury? ☐ Yes ☐ No
When and where? _____

_____

Are you currently receiving treatment from a Department of Veterans Affairs medical facility or Vet Center? If yes, where? _____

Mental Health History

Have you ever been in counseling before? ☐ Yes ☐ No
If yes, describe in detail what you were in counseling for, when, and where: _____

_____

Are you now or have you ever been depressed? ☐ Yes ☐ No
If yes, describe in detail including when, where, and the circumstances: _____

_____

_____

Have you ever been diagnosed with post-traumatic stress disorder (PTSD)?
☐ Yes ☐ No When and where? _____

_____
Have you ever been diagnosed with depression or another mental health problem? ☐ Yes ☐ No
When and where? _____

_____

_____

Have you ever been hospitalized for mental health disorder (including PTSD)? ☐ Yes ☐ No
If yes, describe in detail the circumstances, when, and where: _____

_____

_____

_____

Have you ever been prescribed medication for PTSD, depression, anxiety, a sleep disorder, etc.?
If yes, list all medications you have taken or are taking and who prescribed or is prescribing the medication: _____

_____

_____

_____

Have you ever taken other substances such as herbals or vitamins for relief? ☐ Yes ☐ No
If yes, list all other substances you have taken and when: _____

_____

_____

Have you ever considered suicide? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No When, where, and how? _____

_____

_____

_____

Do any of your immediate family members have a history of mental illness? ☐ Yes ☐ No
If yes, please describe in detail: _____

_____

Are you currently receiving any treatment or counseling from a Department of Veterans Affairs medical facility or Vet Center? If yes, where? _____

Effects of Violence on Children in Your Household

Have the children in your household ever seen you be violent? ☐ Yes ☐ No

Describe their reaction:

Have the children ever seen your partner with injuries resulting from your violence?
☐ Yes ☐ No Describe what they saw:

Where were the children while the violence was happening?

How do you think your violence has affected your children? Your partner's children?

Have you ever been reported to child protective services for child abuse/neglect? If so, when and where and describe in detail the circumstances:

Do you believe the children in your household could benefit from information or support to help them deal with the effects of the violence they have heard or witnessed?
If yes, describe what you think is needed:

Assessment of Types of Abuse and Tactics

Almost all couples argue or fight. What happens when you and your partner have disagreements? Which of the following behaviors do you use?

Emotional Abuse:
___ Put downs ___ Name calling ___ Humiliation
___ Making partner do something degrading

Describe:

Intimidation:
___ Throwing or breaking things ___ Punching walls/doors ___ Screaming and yelling ___ Pounding fists ___ Blocking partner's path ___ Hurting pet(s)
___ Pulling phone from wall ___ Stealing/destroying property
___ Giving angry stares and looks ___ Saying things to scare partner
___ Driving recklessly with partner in car

Describe:

Threats:

___ To harm/kill your partner ___ Telling others you are going to kill your partner
___ To use a weapon ___ To kill yourself
___ To kill partner's pet(s) ___ To take the children away
___ To destroy property ___ To family, friends, coworkers, children
___ To hit or throw something at partner
___ To report partner to child protection, IRS, INS, or other authority

Describe:

Physical abuse:

___ Hitting ___ Slapping ___ Grabbing around the neck
___ Kicking ___ Pushing/shoving ___ Choking/strangling
___ Pulling hair ___ Restraining ___ Punching
___ Biting ___ Spanking ___ Hitting with any object
___ Hitting, pushing, or shoving partner while she was pregnant

Describe (include how many times):

Stalking:

___ Following ___ Making harassing phone calls
___ Sending harassing emails/text messages ___ Creating disturbances at partner's work
___ Listening to phone conversations ___ Opening mail
___ Reading email ___ Spying on partner
___ Monitoring who partner goes out with, where they go, what they do

Describe (Assess ability to harass and abuse over the Internet):

Isolation:

___ Keeping partner away from family and friends
___ Ignoring partner, giving the silent treatment, or hanging up on partner
___ Scaring or threatening partner's family and friends so they stop coming around

Describe:

Sexual Abuse:

___ Forcing partner to have sex ___ Engaging in violent sex
___ Attacking breasts or genitals ___ Being unfaithful
___ Using drugs/alcohol/pornography to coerce sex
___ Forcing sex or pressuring for sex even when separated
___ Forcing partner to engage in unwanted sexual behavior (for example, watch pornography, engage in prostitution, watch you have sex with someone else)

Describe:

Coercion:

___ Controlling children ___ Controlling finances ___ Telling partner how to dress or act
___ Controlling partner in a way that interferes with work, education, or other personal activities
___ Forcing partner do something illegal
___ Pressuring partner to drop charges or Order for Protection

Describe:

Economic Abuse:

___ Preventing partner from working outside the home ___ Refusing to pay child support
___ Forcing partner to ask/beg for money ___ Keeping checkbook from partner
___ Withholding information about family income
___ Making major financial decisions without partner's input
___ Denying partner basic needs such as food, housing, clothing, transportation or medical care
___ Preventing partner from having money for own use

Describe:

Minimizing, denying, blaming:

___ Making light of the abuse/violence ___ Saying it is partner's fault
___ Saying it didn't happen ___ Blaming someone or something else
___ Take no responsibility for the abuse/violence

Describe:

Using Children:

___ Telling children partner is a bad parent ___ Using visitation to harass partner
___ Telling children they do not have to follow partner's rules
___ Using children to threaten partner

Describe:

Appendix D: IPV PERPETRATION SCREENING TOOL

Date_____

IPV perpetration:

- Have you ever hurt or threatened your partner (wife/husband/girlfriend/boyfriend)?
- Have you ever pushed, grabbed, slapped, choked, or hit your partner?
- Have you ever forced sex or made your partner perform sexual acts which your partner did not want to do?

Additional questions focused on coercive control:[2]

- Have you ever restricted your partner's freedom or kept her/him from doing things that were important to her/him?
- Have you ever belittled, insulted, or blamed your partner?

A positive response to any of these questions would indicate the need for further assessment.

[2] Questions focused on coercive control may also be asked in a bi-directional manner. Some examples are found at http://www.futureswithoutviolence.org/userfiles/file/HealthCare/improving_healthcare_manual_2.pdf .

Appendix E: ABUSIVE BEHAVIOR INVENTORY (ABI – OFFENDER FORM)

Here is a list of behaviors that many men use with their partners. We would like you to estimate how often these behaviors occurred during your relationship with your current wife/partner. *Your answers are strictly confidential.*

CIRCLE a number of each of the items listed below to show your closest estimate of how often it happened in your relationship with your current wife/partner.

1 = NEVER
2 = RARELY
3 = OCCASIONALLY
4 = FREQUENTLY
5 = VERY FREQUENTLY

1.	Called her names and/or criticized her.	1 2 3 4 5
2.	Tried to keep her from doing something she wanted to do. (Examples: going out with friends, going to meetings)	1 2 3 4 5
3.	Gave her angry stares or looks.	1 2 3 4 5
4.	Prevented her from having money for her own use.	1 2 3 4 5
5.	Ended a discussion with her and made the decision yourself.	1 2 3 4 5
6.	Threatened to hit or throw something at her.	1 2 3 4 5
7.	Pushed, grabbed or shoved her.	1 2 3 4 5
8.	Put down her family and friends.	1 2 3 4 5
9.	Accused her of paying too much attention to someone or something else.	1 2 3 4 5
10.	Put her on an allowance.	1 2 3 4 5
11.	Used the children to threaten her. (Examples: told her that she would lose custody, said you would leave town with the children).	1 2 3 4 5
12.	Became very upset with her because dinner, housework or laundry was not ready when you wanted it, or done the way you thought it should be.	1 2 3 4 5

1 = NEVER
2 = RARELY
3 = OCCASIONALLY
4 = FREQUENTLY
5 = VERY FREQUENTLY

13. Said things to scare her. (Example: told her something bad would happen, threatened to commit suicide)	1 2 3 4 5
14. Slapped, hit or punched her.	1 2 3 4 5
15. Made her do something humiliating or degrading. (Example: begging for forgiveness, having to ask your permission to use the car or do something).	1 2 3 4 5
16. Checked up on her. (Examples: listened to her phone calls, checked the mileage on the car, called her repeatedly at work).	1 2 3 4 5
17. Drove recklessly when she was in the car.	1 2 3 4 5
18. Pressured her to have sex in a way that she didn't like or want.	1 2 3 4 5
19. Refused to do housework or childcare.	1 2 3 4 5
20. Threatened her with a knife, gun or other weapon.	1 2 3 4 5
21. Spanked her.	1 2 3 4 5
22. Told her that she were a bad parent.	1 2 3 4 5
23. Stopped her or tried to stop her from going to work or school.	1 2 3 4 5
24. Threw, hit, kicked or smashed something.	1 2 3 4 5
25. Kicked her.	1 2 3 4 5
26. Physically forced her to have sex.	1 2 3 4 5
27. Threw her around.	1 2 3 4 5
28. Physically attacked the sexual parts of her body.	1 2 3 4 5
29. Choked or strangled her.	1 2 3 4 5
30. Used a knife, gun, or other weapon against her.	1 2 3 4 5

Appendix F: ABUSIVE BEHAVIOR INVENTORY (ABI – PARTNER FORM)

Here is a list of behaviors that many women report have been used by their partners or former partners. We would like you to estimate how often these behaviors occurred during your relationship with your current husband/partner. *Your answers are strictly confidential.*

CIRCLE a number of each of the items listed below to show your closest estimate of how often it happened in your current relationship with your husband/partner.

1 = NEVER
2 = RARELY
3 = OCCASIONALLY
4 = FREQUENTLY
5 = VERY FREQUENTLY

1.	Called you names and/or criticized you.	1 2 3 4 5
2.	Tried to keep you from doing something you wanted to do. (Examples: going out with friends, going to meetings)	1 2 3 4 5
3.	Gave you angry stares or looks.	1 2 3 4 5
4.	Prevented you from having money for your own use.	1 2 3 4 5
5.	Ended a discussion with you and made the decision himself.	1 2 3 4 5
6.	Threatened to hit or throw something at you.	1 2 3 4 5
7.	Pushed, grabbed or shoved you.	1 2 3 4 5
8.	Put down your family and friends.	1 2 3 4 5
9.	Accused you of paying too much attention to someone or something else.	1 2 3 4 5
10.	Put you on an allowance.	1 2 3 4 5
11.	Used the children to threaten you. (Examples: told you that You would lose custody, said he would leave town with the children).	1 2 3 4 5
12.	Became very upset with you because dinner, housework or laundry was not ready when he wanted it, or done the way he thought it should be.	1 2 3 4 5

1 = NEVER
2 = RARELY
3 = OCCASIONALLY
4 = FREQUENTLY
5 = VERY FREQUENTLY

13. Said things to scare you. (Example: told you something bad would happen, threatened to commit suicide)	1 2 3 4 5
14. Slapped, hit or punched you.	1 2 3 4 5
15. Made you do something humiliating or degrading. (Example: begging for forgiveness, having to ask his permission to use the car or do something).	1 2 3 4 5
16. Checked up on you. (Examples: listened to you phone calls, checked The mileage on your car, called you repeatedly at work).	1 2 3 4 5
17. Drove recklessly when you were in the car.	1 2 3 4 5
18. Pressured you to have sex in a way that you didn't like or want.	1 2 3 4 5
19. Refused to do housework or childcare.	1 2 3 4 5
20. Threatened you with a knife, gun or other weapon.	1 2 3 4 5
21. Spanked you.	1 2 3 4 5
22. Told you that you were a bad parent.	1 2 3 4 5
23. Stopped you or tried to stop you from going to work or school.	1 2 3 4 5
24. Threw, hit, kicked or smashed something.	1 2 3 4 5
25. Kicked you.	1 2 3 4 5
26. Physically forced you to have sex.	1 2 3 4 5
27. Threw you around.	1 2 3 4 5
28. Physically attacked the sexual parts of your body.	1 2 3 4 5
29. Choked or strangled you.	1 2 3 4 5
30. Used a knife, gun, or other weapon against you.	1 2 3 4 5

Appendix G: DANGEROUSNESS/RISK ASSESSMENT PROTOCOL PERPETRATOR

►All persons identifying IPV perpetration in their relationship will be screened for dangerousness/risk factors in their relationship. Use this form for persons that are identified as the primary perpetrator of IPV. Assess the following risks: 1). the current risk for physical violence; 2). suicidal intent; and 3). homicidal intent. Use the following scripted protocol for assessment and response of each.

Risk of physical violence:[3]

- Briefly describe your use of physical force against your partner: (List tactics of physical and psychological abuse)

  _____

  _____

- Have you ever injured your partner or anyone else? _____ What types of injuries were sustained?

  _____

  _____

- When was the last time you were physically violent towards your partner?

  _____

- Has the violence increased, decreased, or stayed the same in the past six months? _____
  Describe:

  _____

- Have you ever used weapons during these incidents of violence? _____
  Describe: _____

- Do you have weapons now? _____ Describe:

  _____

- Have you ever followed your partner to work or followed them when they were out in the community? _____

[3] Adaptation from: Ganley, A. (1995). Health care responses to perpetrators of domestic violence. In D. Lee, N. Durborow, & P. Salber, *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers.* San Francisco, CA: The Family Violence Prevention Fund

- Have you ever prevented her/him from leaving when they wanted to leave?
  _____
- Were you ever drinking or using drugs during any of the violent incidents? _____
  If so, describe: _____

- Have the police ever been called? _____ If so, what happened?
  _____

- Have you ever seriously harmed a previous partner/s or others? _____
  Describe: _____

- Have you ever thought about hurting or killing your partner? _____
  If so, when was the last time? _____
  (If yes, continue during homicide assessment.)

- Have you ever thought about hurting or killing the children or anyone else? _____ If so, when was the last time? _____
  (**If yes, continue during homicide assessment.)**

- Have you ever thought about hurting or killing yourself? _____ If yes, when was the last time?
  _____
  (If yes, continue during suicide assessment.)

► Yes, to any of these questions indicates an increased risk. Yes to either or both the suicide and homicide questions should be taken very seriously and further evaluation may be required once the suicide and homicide assessments are completed. If there is no immediate risk, but there is an on-going pattern, determine the perpetrator's motivation to receive specific help for the domestic violence. Provide domestic violence resource information at this time and talk about how to access those resources.

Suicidal Intent (continued from violence assessment):[4]

- When you last thought about killing yourself, did you think about how you would do it?
  _____

- Do you have the _____ (means as identified above)? _____

- Have you attempted suicide in the past? _____
  If yes, when? _____ and what happened?
  _____

- Have you ever thought of hurting or killing someone else before killing yourself?
  _____
  (If yes, move to homicide assessment.)

- Are you planning to kill yourself? _____

► If the perpetrator indicates that he/she is thinking about suicide, has the means, a plan, and the intent to act on it, let them know that they will need to stay until they can be evaluated further. Contact the psychiatric and/or emergency services for an evaluation (immediate intervention will depend on whether the person is a military veteran or service member and the emergency protocols for the setting).

[4] Adaptation from: Gerlock, AA (2005, summer). Domestic violence: Recognizing and responding to victims and perpetrators in the health care setting. (Two-part on-line training module for healthcare professionals). Supported by funds from a training grant from the Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration, Dept. of Health and Human Services, to the Univ. of Washington, School of Nursing, GRANT #D11HP03123-01-00.

Homicidal Intent (continuation from violence assessment):[5]

- When was the last time you thought about killing or injuring your partner? _____
- What did you think about doing? _____
- Do you have the _____ (means as identified above), to do this? _____
- When was the last time you thought about killing or injuring your (family, friends, or other)? _____
- What did you think about doing to them? _____
- Do you have the _____ (means as identified above), to do this? _____
- Have you ever tried to kill your partner before? _____ If so, when? _____ and, what happened? _____
- Have you ever tried to kill your (family, friends, or other) before? _____ If so, when? _____ and what happened? _____
- Do you intend to harm (partner, family, friends, or other)? _____

► Homicidal thinking and planning should be taken very seriously. If the perpetrator indicates they have been thinking about killing someone (partner, family, friends, or other), inform them that this is one of those situations talked about where a further evaluation is needed, and includes limits to their confidentiality. Let him/her know that it is our priority to keep everyone safe. Contact the psychiatric and/or emergency services to arrange for an evaluation for hospitalization. You will need to stay with the perpetrator until this can be determined and notifications are made if needed (immediate emergency intervention will depend on whether the person is a military veteran or service member and the emergency protocols for the setting).

[5] Adaptation from: Gerlock, AA (2005, summer). Domestic violence: Recognizing and responding to victims and perpetrators in the health care setting. (Two-part on-line training module for healthcare professionals). Supported by funds from a training grant from the Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration, Dept. of Health and Human Services, to the Univ. of Washington, School of Nursing, GRANT #D11HP03123-01-00.

Appendix H: DANGEROUSNESS/RISK ASSESSMENT PROTOCOL ADULT VICTIM

►Persons identifying IPV victimization will be screened for dangerousness/risk factors in their relationship. Use this form for individuals who are identified as the primary victim of IPV. In a case where the partner is a primary perpetrator, then use the Dangerousness/Risk Assessment Protocol for Perpetrators. Assess the following risks: 1). the current risk for physical violence; 2). suicidal intent; and 3). homicidal intent. Use the following scripted protocol for assessment and response of each.

Risk of physical violence:[6]

- Briefly describe your partner's use of physical force against you: (List tactics of physical and psychological abuse)
  _____
  _____
- Have you (or anyone else) ever been injured? _____ Who and what types of injuries were sustained?
  _____
  _____
- When was your partner last physically violent towards you?
  _____
- Has he/she made threats to kill you or the children? If yes describe:
  _____
  _____
- Has the violence or threats increased in frequency or severity? _____
  Describe: _____
- Does he/she have weapons at home? If yes describe:
  _____
- Has he/she ever used weapons towards you or the children? If yes describe:
  _____
- Does he/she use drugs or alcohol? (if yes, type and frequency)
  _____

[6] Campbell, J. C. (2004, Dec). Helping women understand their risk in situations of intimate partner violence. *Journal of Interpersonal Violence*. *19*(12), 1464-77.
Ganley, A. L. (1995). Health care responses to perpetrators of domestic violence. In D. Lee, N. Durborow, & P.R. Salber (Eds.), *Improving the health care response to domestic violence: A resource manual for health care providers* (pp.89-106). San Francisco: The Family Violence Prevention Fund.

- Has he/she ever followed you to work, or any of your outside activities? (if yes, describe)
  _____

- Has he/she ever threatened to or injured or killed any of your family, friends, or helpers? (if yes, describe)
  _____

- Has he/she ever seriously harmed a previous partner/s or others? (if yes, describe)
  _____

- Have you attempted to leave or are you attempting to do so now? (if yes describe)_____

- Are you afraid of him/her? _____ What is he/she doing that makes you afraid?
  _____

►After reviewing, ask the victim if she/he feels they are in danger of being seriously injured or killed. Discuss this risk with her/him and the options. Let the victim know the risk factors that affect the dangerousness of the situation. Talk with her/him about the referral information you have given them and how to access help (shelters, Hotline, victim advocacy for their area/setting, etc., or emergency medical contact). Determine the need for immediate intervention to prevent injury or death (discuss intervention specific to setting or community). Discuss with her/him future follow up contact by phone.

Suicidal Intent:[7]

- Have you ever felt so bad that you didn't want to go on living? _____
- Have you ever thought about killing yourself? _____
- Have you thought about how you would do it? _____
- When did you last think about this? _____
- Do you have the _____ (means as identified above)? _____
- Have you ever attempted suicide in the past? _____
- Do you plan to kill yourself? _____

► If the person indicates that she/he is thinking about suicide, has the means, a plan and intent to act on it, let them know that you will need to stay with them until they can be evaluated. Contact psychiatric and/or emergency services to arrange for evaluation. (This will vary depending on whether she/he is a military veteran or service member or not, whether they are receptive to receiving help, and/or if a community Mental Health Professional will need to be alerted).

Homicidal Intent:[8]

- Have you ever thought about injuring or killing your partner? _____
- What did you think about doing to your partner?
  _____
- When did you last think about this? _____
- Do you have the _____ (means as identified above), to do this?
  _____
- Have you ever tried this in the past? (if so, when) _____

[7] Adaptation from: Warshaw, C. (1995). Identification, assessment and intervention with victims of domestic violence. In D. Lee, N. Durborow, & P. Salber, *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers.* San Francisco, CA: The Family Violence Prevention Fund.

[8] Adaptation from: Gerlock, AA (2005, summer). Domestic violence: Recognizing and responding to victims and perpetrators in the health care setting. (Two-part on-line training module for healthcare professionals). Supported by funds from a training grant from the Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration, Dept. of Health and Human Services, to the Univ. of Washington, School of Nursing, GRANT #D11HP03123-01-00.

- (if so) What happened? _____
- What is your intent to follow through with this? _____

► When assessing for homicidal intent differentiate between anger and 'wishing they were dead' and intent to kill. If the person indicates that she/he does have the intent and a plan to do so, inform them that this is one of those situations talked about (limits to confidentiality) that will need further evaluation. Let her/him know that our priority is to keep everyone safe. Sometimes victims feel like striking back at their partner, but this never turns out positive for anyone. Contact psychiatric, and/or emergency services to arrange for an evaluation (this will vary depending upon whether the person is a military veteran or service member, whether she/he is receptive to receiving help, and/or if a community Mental Health Professional will need to be contacted).

Appendix I: PTSD SCREENING TOOL

The PTSD screen below was developed for primary care medical settings (Primary Care PTSD Screen for DSM-5; PC-PTSD-5) and consists of five questions.[9] The first question is to determine if someone has had exposure to traumatic event(s). If a person denies exposure, the screen is complete with a score of 0. However, if he or she has experienced a traumatic event or events during their life, they are instructed to respond with either yes or no to the following five questions. Preliminary validation studies suggest that the PC-PTSD-5 should be considered positive, if a respondent answers "yes" to any three of the five questions about how the traumatic event(s) has affected him or her over the past month. A determination of a PTSD diagnosis would require a thorough assessment by a person experienced in conducting that type of evaluation.

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: A serious accident or fire; a physical or sexual assault or abuse; an earthquake or flood; seeing someone be killed or seriously injured; having a loved one die through homicide or suicide. Have YOU ever experienced this kind of event? YES/NO
[If No, screen total = 0. Please stop here.]

If yes, please answer these questions. In the past month, have you…

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?
   YES/NO

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
   YES/NO

3. Been constantly on guard, watchful, or easily startled?
   YES/NO

4. Felt numb or detached from others, activities, or your surroundings?
   YES/NO

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
   YES/NO

[9] Prins, A, Ouimette, P, Kimerling, R, et al. (2003). The primary care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry*, 9, 9-14.
Prins, A., Bovin, M. J., Smolenski, D. J., Mark, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., Kaloupek, D. G., Schnurr, P. P., Pless Kaiser, A., Leyva, Y. E., & Tiet, Q. Q. (2016). The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine, 31,* 1206-1211. doi:10.1007/s11606-016-3703-5

Appendix J: TBI SCREENING TOOL

A screen to determine military-related TBI involves a few questions. This is only a screen to determine if a brain trauma occurred. Establishing a diagnosis of a TBI needs to be done by a health care professional with that expertise. However, these few questions will help clarify if a referral needs to be made.[10]

Section 1: The service member/veteran experienced the following events:

- Blast or explosion IED (improvised explosive device), RPG (rocket propelled grenade), land mine, grenade, etc.
- Vehicular accident/crash (any vehicle, including aircraft)
- Fragment wound or bullet wound above the shoulders
- Fall
- Blow to head (head hit by falling/flying object, head hit by another person, head hit against something, etc.
    - Other injury to head

[Section 1 establishes a trauma to the head.]

Section 2: The service member/veteran had the following symptoms immediately afterwards:

- Losing consciousness/knocked out
- Being dazed, confused or "seeing stars"
- Not remembering the event
- Concussion
- Head injury

[Section 2 establishes symptoms and injury immediately at the time of the event.]

Section 3: The service member/veteran had the following problems which began or got worse afterwards:

- Memory problems or lapses
- Balance problems or dizziness
- Sensitivity to bright light
- Irritability
- Headaches
- Sleep problems

[Section 3 establishes the symptoms after the event.]

Section 4: The service member or veteran relates he/she is currently having or has had the following symptoms within the past week:

- Memory problems or lapses
- Balance problems or dizziness
- Sensitivity to bright light

[10] For information on TBI symptoms and screening, see https://www.polytrauma.va.gov/system-of-care/

- Irritability
- Headaches
- Sleep problems

[Section 4 establishes ongoing symptoms and problems that are connected to the injury.]

An individual who has had an injury above the shoulders, who had some symptoms (does not have to have all the symptoms listed) immediately after the injury, and then continues to have some symptoms may have a TBI. Further assessment would be needed to establish the diagnosis.

Appendix K: ALCOHOL ABUSE SCREENING TOOL

The screening questions come from the AUDIT-C. It can be conducted quickly and identifies if alcohol is a problem. It provides a range of responses. There are cut-off scores that establish if someone has an alcohol misuse/abuse problem. There are also recommended alcohol limits established by health care professionals for both men and women. This quick screening tool will assist in making a decision whether or not to request a thorough assessment. (For information on and to download the AUDIT, go to http://www.healthquality.va.gov/ [Under the Mental Health section, click on "Substance Use Disorder"] U.S. Department of Veterans Affairs.) There are also tools available to help establish what constitutes a drink.[11]

- How often did you have a drink containing alcohol in the past year?[12]
  - Never (0 points)
  - Monthly or less (1 point)
  - 2-4 times monthly (2 points)
  - 2-3 times weekly (3 points)
  - 4 or more times weekly (4 points)

- How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

  - 0 drinks (0 points)
  - 1 to 2 drinks (0 points)
  - 3 to 4 drinks (1 point)
  - 5 to 6 drinks (2 points)
  - 7 to 9 drinks (3 points)
  - 10 or more drinks (4 points)

- How often did you have six or more drinks on one occasion in the past year?

  - Never (0 points)
  - Less than monthly (1 point)
  - Monthly (2 points)
  - Weekly (3 points)
  - Daily or almost daily (4 points)

[11] For comparisons on what is a standard drink size, see http://rethinkingdrinking.niaaa.nih.gov/WhatCountsDrink/WhatsAstandardDrink.asp.

[12] Frank, D., DeBenedetti, A. F., Volk, R. J., Williams, E.C., Kivlahan, D. R., Bradley, K.A. Effectiveness of the AUDIT-C as a screening test for alcohol misuse in three race/ethnic groups. *Journal of General Internal Medicine*. 2008 Jun 1; 23(6), 781-7.

A positive AUDIT-C score of > 4 for men and > 3 for women means the individual is probably drinking at unhealthy levels. The higher the AUDIT-C score the greater the health risks.[13]

Another frequently used alcohol screen is the CAGE.[14] The CAGE targets behaviors associated with problem drinking. Scores of two or greater were found to be a trustworthy screen to identify problem drinkers. Question number 4 below (Eye-opener) has been found to be the most reliable question of the four and is sometimes used by health care clinicians as a quick screen for alcoholism. This screen is not meant to be a diagnostic test but can be used as a quick measure of problem drinking behaviors.

1. Have you ever felt you needed to **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt **G**uilty about drinking?
4. Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or to get rid of a hangover?

[13] For information on the AUDIT-C (how to use it, what the scores mean, how to respond to positive scores, etc.), see http://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs.cfm#3

[14] Mayfield, D, McLeod, G., & Hall, P. (1974, Oct.) The CAGE questionnaire: Validation of a new alcoholism screening instrument. *The American Journal of Psychiatry*, 131 (10), 1121-1123.
Ewing, JA (1984). Detecting Alcoholism: The CAGE Questionnaire. *JAMA*, 252, 1905-1907

Appendix L: DRUG ABUSE SCREENING TOOL

The Drug Abuse Screening Test (DAST)[15] is a reliable screening tool to determine drug misuse/abuse. The DAST-10 is a shortened version that maintains reliability and is used for screening purposes only. Drug abuse refers to the use of either prescribed or over-the-counter drugs in excess of the directions, as well as any nonmedical use of drugs. The typical drugs of abuse include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers, barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), and narcotics (e.g., heroin). The person responds to the following questions with either "yes" or "no" to use over the past year.

DAST-10:

- Have you used drugs other than those required for medical reasons?
- Do you abuse more than one drug at a time?
- Are you unable to stop using drugs when you want to?
- Have you ever had blackouts or flashbacks as a result of drug abuse?
- Does your spouse/partner (or parents) ever complain about your involvement with drugs?
- Have you neglected your family because of your use of drugs?
- Have you engaged in illegal activities in order to obtain drugs?
- Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
- Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?

Each "yes" response is scored as 1. A score of 0 indicates no problem. However, a score of 2 or more indicates the need for further assessment and possibly intervention.

[15] Skinner, HA (1982). The Drug Abuse Screening Test. *Addictive Behaviors*, 7, 363-371.

Appendix M: DEPRESSION SCREENING TOOL

The following depression screen is an abbreviated version of the longer Patient Health Questionnaire-9 (PHQ-9) which is frequently used in health care settings.[16] This screen takes only the first two questions of the longer 9-question screen. The PHQ-2 asks two critical questions to help determine if someone is depressed.

PHQ-2:[17]

Over the past two weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things:
  - Not at all (0 points)
  - Several days (1 point)
  - More than half the days (2 points)
  - Nearly every day (3 points)
- Feeling down, depressed or hopeless:
  - Not at all (0 points)
  - Several days (1 point)
  - More than half the days (2 points)
  - Nearly every day (3 points)

The PHQ-2 score ranges from 0-6. A PHQ-2 cutoff score of 3 (or more) is a positive screen for depression.

[16] The MacArthur Initiative on Depression and Primary Care at Dartmouth and Duke. Depression Management Tool Kit. Hanover, NH: 3CM, LLC. 2009.

[17] Kroenke, K, Spitzer, RL, Williams, JB. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. Medical Care, 41, 1284-1294. You can access a copy online and a discussion of properties at www.cqaimh.org/pdf/tool_phq2.pdf.