RISE: RECOVERING FROM INTIMATE PARTNER VIOLENCE THROUGH STRENGTHS AND EMPOWERMENT

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10/8/2021
Learning Objectives

• Describe the theoretical foundation underlying the RISE program;

• Summarize the evidence-base supporting the utility of RISE;

• Identify 2-3 lessons learned as a training and implementation program is developed to more broadly roll-out this intervention in VHA.
Disclaimers

The content in this presentation is the result of a review of pertinent literature, as well as the scientific studies, program evaluation and practice experience of the presenters.

This presentation contains content related to intimate partner violence and trauma.

Given the prevalence of IPV in the general population, attendees are urged to be self-aware and seek assistance if experiencing IPV or disturbed by any of the content.
Conflicts of Interest

- Dr. Iverson (co-presenter) is the primary developer and evaluator of the RISE program. She works full-time for the Women’s Health Sciences Division of the National Center for PTSD, which is located at the VA Boston Healthcare System. She does not receive any direct compensation from the program materials.

- The other facilitators assist with the implementation of the RISE program within the VHA Healthcare System. They have no conflicts of interest to report.
Intimate Partner Violence (IPV) Definitions

- **Physical violence, sexual violence, stalking or psychological aggression (including coercive acts) from a past or current intimate partner (CDC)**

**Physical:**
- Hitting, kicking, strangulation/chocking, threats of violence, Etc.

**Sexual:**
- Threatening or forcing a partner to take part in a sex act when he or she does not consent

**Psychological:**
- Threats, name calling, intimidation, economic control, isolation, etc.

**Stalking:**
- Repeated following, harassing, or unwanted contact resulting in fear
 Nearly 1 in 4 women report having experienced severe physical violence from an intimate partner in their lifetime.

About 1 in 7 men report having experienced severe physical violence from an intimate partner in their lifetime.

About 1 in 6 women have experienced contact sexual violence by an intimate partner.

And 1 in 14 men have experienced contact sexual violence by an intimate partner.

10% of women and 2% of men report having been stalked by an intimate partner.

www.cdc.gov/violenceprevention
THE IMPACT OF DOMESTIC VIOLENCE

Domestic violence is a pattern of coercive control and abusive behaviors in any intimate or familial relationship that are used to gain and maintain power and control over another. Domestic violence can look many different ways, including:

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Unmet Needs</th>
<th>Child Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 4 women</td>
<td>In one day in 2017, victims in AZ made 366 requests for services that went unmet due to lack of program resources. Of these requests, 74% were for housing.</td>
<td>Individuals who witnessed IPV as children are 2x more likely to become either victims or perpetrators of IPV.</td>
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<tr>
<td>1 in 10 men</td>
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<td></td>
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<td>Wiltz et al. (2003)</td>
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</tbody>
</table>

**Economic Impact**

The lifetime cost of IPV per female and male victim is about $104,000 and $23,000, respectively.

**Health Consequences**

- Injury
- Depression
- Post traumatic stress
- Chronic pain
- Gastrointestinal issues
- Sexually transmitted infections

**Ways to Help**

Believe • Donate • Vote • Organize • Collaborate

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ARIZONA COALITION TO END SEXUAL & DOMESTIC VIOLENCE

602-279-2900
info@acessadv.org
www.acessadv.org
Subgroup Differences

No racial differences (after controlling for SES)

Higher education is a *protective* factor

Lower household income is *risk* factor

Sexual & gender minority persons have higher risk..
What Experts Are Seeing:

• Starting in mid-March, Phoenix police reported a jump in domestic violence calls.

• Issues – people calling for help and whispering because the person using IPV behaviors is in the next room. Individuals “weaponizing COVID”.

• The ACESDV says in Arizona, one or more children witness a domestic violence incident every 44 minutes. The Centers for Disease Control and Prevention say at least 1 in 7 children experienced abuse or neglect in the past year.

From Arizona Effort Aims To Help Families Facing 'Astronomical' Stress, July 22, 2020
IPV is Common Among Women Veterans

- 1.6 times more likely to experience lifetime IPV relative to women who never served in the military (Dichter et al., 2011)

- About 1 in 5 women using VHA primary care have experienced past-year IPV (Kimmerling et al., 2016)
VETERAN-CENTRIC FACTORS:

- Post-Traumatic Stress
- Military Family Life Stress
- Separation & Isolation
- Mental Health Concerns
- Alcohol and/or Drug Use
- Loss of Trust/Moral Distress
- Traumatic Brain Injury
  - Increased Anger
  - Decreased Frustration Tolerance

May lead to Increased Risk of:
- Divorce/Broken families
  - Loss of support
  - Homelessness
  - Joblessness
  - Poverty
- Increased healthcare needs
  - Justice involvement
  - Suicide and/or Homicide
October is Domestic Violence Awareness Month

VA INTIMATE PARTNER VIOLENCE ASSISTANCE PROGRAM
IPV is a Cross-Cutting Issue in Healthcare

- Poorer overall physical health, chronic pain, head injuries, etc. (Dutton, 2009; Galovski et al., 2021; Iverson et al., 2019)

- Lower self-efficacy, empowerment, and quality of life (Dardis et al., 2018; Iverson et al., 2017; McLean & Follette, 2017)

- Elevated anxiety, depression, PTSD, and suicidality (Dichter et al, 2017; Iverson et al., 2013)

- Frequent use of healthcare services (Bonomi et al., 2009; Dichter et al., 2018)
Opportunities for Healthcare Response

Injury and chronic illness

Emotional pain

Psychological disorders

Increased use of healthcare system

Opportunity for screening

Inadequate in-house intervention options

1 in 3 women experience IPV

Suicidality and death
THE POLICY

VHA DIRECTIVE 1198, INTIMATE PARTNER VIOLENCE ASSISTANCE PROGRAM (JANUARY 24, 2019)

POLICY: It is VHA policy that every VA medical facility implements and maintains an IPVAP. Veterans, their intimate partners, and employees impacted by IPV (experiencing or using) will have access to services including resources, assessment intervention and/or referrals to VA or community agencies as deemed appropriate and clinically indicated.
### IPVAP IS COMPREHENSIVE & INTEGRATED

| Raising Awareness | • IPV campaigns, awareness events, materials  
| | • Staff training & education |
| Building Community Partnerships | • Outreach events  
| | • Building partnerships & resources |
| Serving those who experience IPV | • Implementing routine screening  
| | • Establishing intervention plan & resources |
| Serving those who use IPV | • Implementing screening/identification plan  
| | • Establishing intervention plan & resources |
| Serving VA Staff | • Building internal collaborations with Employee Assistance, Workplace Safety, etc. |
What are some first steps in approaching our case example?

- Screening
- Trauma informed care
- But they were asked already and said everything is fine.....
- What if they say they are experiencing IPV....
Given the significant and rising risk – there is a strong need for responses that are evidence-based to assist individuals experiencing IPV.

Complementing IPV screening efforts

- Growing evidence and clinical recommendations propelled VHA to increase implementation of IPV screening programs across VA settings
- However, less is known about how to intervene following IPV disclosure
  - Resources and safety planning
  - Women’s needs, circumstances and preferences differ
  - Clinicians desire more guidance and a framework for intervention

What should intervention look like?

- Clinical experience
- Existing literature
- CDA research
  - Focus groups & interviews with providers and women veterans
  - National survey of women veterans

Iverson, Wiltsey Stirman, Street, et al. & Vogt (2016); Dichter, Wagner, Goldberg, & Iverson (2015); Iverson et al. (2014).
Recovery from IPV through Strengths and Empowerment (RISE)

Recovering from IPV through Strengths and Empowerment

RISE: Provider Manual

Katherine M. Iverson, Ph.D. & Megan R. Gerber, MD
VA Boston Healthcare System and Boston University

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IPV Erodes Self-Efficacy

**Self-efficacy**: Optimistic self-beliefs to cope with an array of difficult events in life

**Invalidation** is a core component of IPV that reduces self-efficacy

- Physical & sexual aggression
- Controlling what he/she does and who he/she sees
- Blaming the person for his/her aggression
- Degrading comments, putdowns, and chastising for ordinary events

These methods create damage well beyond the element of fear and control, extending into a far darker place as they erode our sense of self-efficacy, confidence, and peace

- Generalize beyond the abusive relationship (e.g., difficulties at work, isolating from others, distrust in ability to make good decisions)

A sense of personal control and confidence are key factors that are associated with increases in psychosocial health and safety among individuals who experience IPV
Empowerment

- Value that individuals are experts in their own lives
- Recognize that people have made the best decisions they could considering their circumstances and helping clients to understand that too
- Appreciates that IPV can happen to anyone
- Individuals have the right to be supported in their decisions about their life choices

Increased Self-Efficacy

Options, choice, and self-determination!

Helping clients understand what their options are and encouraging their choices
Conceptual Model of Impact of RISE on Psychosocial Outcomes

**Treatment Content and Characteristics**

- Safety planning
- Education on health effects of IPV and warning signs
- Improving coping and self-care
- Enhancing social support
- Making difficult decisions
- Connecting with resources & Moving Forward

**Primary/Immediate Goals**

- Increased:
  - Empowerment*
  - Self-efficacy*
  - Patient activation
  - Valued action

**Secondary/Longer-term Outcomes**

- Increased:
  - Mental health
  - Physical health
  - Safety behaviors
  - Service use

- Reduced:
  - IPV

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*Empowerment is about taking control over your own life and making positive decisions based on what you want

*Self-efficacy refers to optimistic self-beliefs to cope with an array of difficult events in life
HOW DOES THIS RELATE TO OUR CASE EXAMPLE?
What is RISE?

- Individualized and veteran-centered
  - Variable-length (1 to up to ≈ 8 sessions)
  - Modular – client select one each session
- Rooted in principles of trauma-informed care and empowerment
  - Choice, flexibility, and autonomy
- MI techniques embedded throughout
  - Collaborative, non-confrontational & values-focused
  - Client-driven goal setting
- SMART goals identified each session
- Compatible with most social work and psychology contexts

Safety Planning
Ways to increase your safety, and that of any children and pets, in different situations, like in an argument or if you are thinking about leaving the relationship through a written worksheet.

The Health Effects and Warning Signs of IPV
Understanding the effects of trauma and IPV on different parts of your life (for example, your physical, mental, and social health, and the well-being of your children). Understanding Warning Signs of IPV, including red flags in partners and the difference between aggressive behavior and assertive behavior.

Improving Coping and Self-Care
Learning about and practicing self-care strategies and ways to relax when you are stressed.

Enhancing Social Support
Learn and practice how to approach friends or family and ask for support.

Making Difficult Decisions
A written exercise that may help you think about your options and make decisions if you are thinking about making a change in your relationship.

Resources and Moving Forward
Learning about resources available in the community for a variety of topics (like housing, employment, legal aid, and restraining orders). Reflect on things you’ve accomplished and plan ahead for life’s ups and downs by identifying red flags to watch out for and ways to RISE up and cope.

Sexual Violence Over the Lifespan
Recognize different forms of sexual violence that are commonly experienced by individuals who experience IPV and make the connection between experiences of sexual violence and health.
**Multiphase Project to Develop, Refine, & Evaluate RISE**

**Phase 1.** Gather stakeholder feedback from VA patients and providers (via focus groups and qualitative interviews) to refine the draft intervention.

**Phase 2.** Formative evaluation of RISE (in the context of an open trial) to refine the intervention and procedures prior to effectiveness testing.

**Phase 3.** Randomized clinical trial to examine the effects of RISE on psychosocial outcomes relative to an enhanced care as usual comparison condition.

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**Strides Toward Recovery From Intimate Partner Violence: Elucidating Patient-Centered Outcomes to Optimize a Brief Counseling Intervention for Women**


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**Recovering From Intimate Partner Violence Through Strengths and Empowerment (RISE): Development, Pilot Testing, and Refinement of a Patient-Centered Brief Counseling Intervention for Women**

Methods: Overview

- RCT with \( n = 60 \) women Veterans over 2 years at the VA Boston Healthcare System
- Participants randomized to either RISE or advocacy-based enhanced care as usual (ECAU) condition
  - Social worker and psychologist clinicians
- Hypothesized that RISE would improve empowerment, self-efficacy patient activation, and valued living more than ECAU
- Primary outcome measures at pre, 10- and 14-weeks post-enrollment
- Qualitative exit interviews with women Veterans and clinicians
  - Rapid content analysis
- Make recommendations to VHA and/or partnered research proposal
Methods: Recruitment and Eligibility

Recruitment

- Participants were recruited from October 2018 to September 2020
- Clinician and self-referrals
- Patient letters and phone calls

Inclusion criteria

- Identify as a woman
- Endorse past-year IPV
- VHA Boston patient
- Willing to be audio recorded

Exclusion criteria

- Imminently suicidal or homicidal
- Active psychosis or untreated bipolar diagnosis
- Participation in open trial
Methods: Procedure

• **Screening**
  • Potential participants completed phone screen with study staff
  • Ineligible study participants were referred to appropriate alternative services

• **Enrollment Session**
  • Obtained informed consent
  • Collected baseline assessment measures
  • Participant was randomly assigned to RISE or ECAU condition
  • Received intervention session immediately following their baseline assessment
    • $n = 6$ completed enrollment and telehealth sessions during the pandemic

• **Assessments**
  • Completed 10-week and 14-weeks after baseline
  • RISE participants completed primary outcome measures prior to RISE sessions 2-6
  • Participants paid up to $150 for completing the 3 assessments
RISE delivered per refined manual
- Based on provider and participant feedback from phase 2, all RISE sessions can be up to 60 minutes
- Graph and discuss self-efficacy scale at beginning of each session
- Variable-length format (1 to up to 6 sessions)
- MI techniques embedded throughout
  - Reflective listening
  - Elicit-provide-elicit
  - Confidence rulers
- Participant selects a module each session based on current needs
- SMART goals identified at the end of each session pertaining to module
- Linkages to VHA services and community services
Enhanced Care As Usual (ECAU)

- One time, 60-minute advocacy-based session
- Supportive comments and validation
- Using the brochure, providers use psychoeducation to discuss:
  - The different forms of IPV (i.e. physical, sexual, psychological, etc.)
  - The effects of IPV on physical, mental, and social health
- Safety planning
- Local and national IPV-related resources
- Linkages to VHA and community resources
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measurement</th>
<th>Scale Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowerment</td>
<td>Personal Progress Scale (PPS-R; Johnson et al., 2005)  α = .89</td>
<td>28 to 196; Higher score = greater personal empowerment</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>General Self-Efficacy Scale (GSES; Schwarzer &amp; Jerusalem, 1995)  α = .88</td>
<td>0-40; Higher score = greater self-efficacy</td>
</tr>
<tr>
<td>Patient Activation</td>
<td>Patient Activation Measure (PAM-13; Hibbard et al., 2005)  α = .88</td>
<td>Calibrated scores range from 0-100; Higher score = higher patient activation</td>
</tr>
<tr>
<td>Valued Living</td>
<td>Valued Living Questionnaire (VLQ; Wilson et al., 2010)  α = .84</td>
<td>Composite scores range 10-100; Higher score = greater valued living</td>
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</tbody>
</table>
## Secondary Outcome Measures

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measurement</th>
<th>Scale Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive Symptoms</td>
<td>Center for Epidemiological Studies- Depression Scale (CES-D; Radloff, 1977) α = .90</td>
<td>0-60; Higher score = greater depressive symptoms</td>
</tr>
<tr>
<td>IPV</td>
<td>Conflict Tactics Scale-Revised (CTS-2; Straus et al, 1996). α = .95</td>
<td>Assesses physical, sexual, and psychological IPV. Higher score = higher IPV</td>
</tr>
<tr>
<td>Satisfaction with</td>
<td>Client Satisfaction Questionnaire (CSQ-8; Larsen et al, 1979) α = .93</td>
<td>Scores range from 8-32; Higher scores = greater satisfaction</td>
</tr>
<tr>
<td>Intervention</td>
<td>Semi-structured interviews</td>
<td>Qualitative</td>
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<tr>
<td>Acceptability</td>
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</tbody>
</table>
Methods: CONSORT Flow Diagram

Assessed via phone for eligibility (n=130)

Excluded (n=70)
- Did not receive care at VA Boston (n=4)
- No past year IPV (n=33)
- Current symptoms of mania (n=7)
- Current symptoms of psychosis (n=6)
- Lost contact (n=14)
- Denied wanting to participate (n=6)

Randomized (n=60)

Allocated to RISE intervention (n=30)
- Received RISE (n=30)

Allocated to Enhanced Care as Usual (n=30)
- Received Enhanced Care as Usual (n=30)

10-week Follow-up

Completed follow-up (n=27)
Did not complete (missed time period) (n=3)

14-week Follow-up

Completed follow-up (n=27)
Did not complete (missed time period) (n=2)
Declined to participate in assessment (n=1)

Analysis

Analysed (n=29)
- Excluded from analysis (n=1)

Analysed (n=30)
Results: Demographic Characteristics (N = 60)

- Age = 39.1 ($SD = 11.9$)
- Race and Ethnicity
  - 55% White
  - 21.7% Black
  - 11.7% Another race
  - 11.7% Multiple races
  - 20% Hispanic
- Sexual orientation
  - 71.6% Heterosexual; 15% Bisexual; 6.7% Lesbian; 6.7% Pansexual
- Past-year IPV
  - 100% psychological; 68% physical; 45% sexual
  - $\approx 50\%$ reported continued involvement with the violent partner
### Results: Baseline Measures (n=60)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>RISE (n = 30)</th>
<th>ECAU (n = 30)</th>
<th>Difference (95% CI)</th>
<th>Statistic</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment (PPS)</td>
<td>129.82 (22.11)</td>
<td>132.25 (24.08)</td>
<td>2.42 (-9.52 to 14.37)</td>
<td>t = 0.41</td>
<td>.69</td>
</tr>
<tr>
<td>Self-Efficacy (GSS)</td>
<td>28.70 (4.63)</td>
<td>29.90 (5.38)</td>
<td>1.2 (-1.39 to 3.79)</td>
<td>t = .93</td>
<td>.36</td>
</tr>
<tr>
<td>Patient Activation (PAM)</td>
<td>65.89 (18.71)</td>
<td>64.62 (16.73)</td>
<td>-1.26 (-10.44 to 7.91)</td>
<td>t = -.28</td>
<td>.78</td>
</tr>
<tr>
<td>Valued Living (VLQ)</td>
<td>49.88 (19.31)</td>
<td>48.88 (16.8)</td>
<td>-1.0 (-10.35 to 8.36)</td>
<td>t = -.21</td>
<td>.83</td>
</tr>
<tr>
<td><strong>Secondary Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Depressive Symptoms</td>
<td>27.21 (10.69)</td>
<td>24.50 (11.76)</td>
<td>-2.71 (2.90 to -8.52)</td>
<td>t = -.94</td>
<td>.35</td>
</tr>
<tr>
<td>Past-year IPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Psychological Aggression</td>
<td>30 (100)</td>
<td>30 (100)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Assault</td>
<td>17 (56.7)</td>
<td>24 (80)</td>
<td>7</td>
<td>χ² = 3.77</td>
<td>.08</td>
</tr>
<tr>
<td>Sexual Coercion</td>
<td>16 (53.3)</td>
<td>11 (36.7)</td>
<td>5</td>
<td>χ² = 1.68</td>
<td>.19</td>
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</tbody>
</table>
Results: RISE Engagement (N=30)

# of Sessions Attended

- 83% ≥ 2 sessions
- 70% ≥ 3 sessions
- 57% ≥ 4 sessions
- 47% ≥ 5 sessions
- 30% = 6 sessions

Modules Selected

- Safety Planning: 33.0%
- Health Effects & Warning Signs of IPV: 60.0%
- Improving Coping & Self-Care: 73.0%
- Enhancing Social Support: 53.0%
- Making Difficult Decisions: 50.0%
- Resources & Moving Forward: 53.0%
## PPS: Empowerment*

<table>
<thead>
<tr>
<th></th>
<th>Within-Group Effect Size</th>
<th>Between-Groups Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>RISE</td>
<td>$d = .82$</td>
<td>$d = 3.46$</td>
</tr>
<tr>
<td>ECAU</td>
<td>$d = .24$</td>
<td></td>
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</table>

*Empowerment over time with RISE and ECAU treatments. The graph shows a significant increase in PPS mean score over sessions, with RISE leading in both within-group and between-groups effect sizes.
<table>
<thead>
<tr>
<th></th>
<th>Within-Group Effect Size</th>
<th>Between-Groups Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>RISE</td>
<td>$d = 1.23$</td>
<td>$d = 1.09$</td>
</tr>
<tr>
<td>ECAU</td>
<td>$d = 0.13$</td>
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**GSS: Self-Efficacy**

![Graph showing self-efficacy scores over time for RISE and ECAU groups.](image)
## PAM: Patient Activation

<table>
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<th>Between-Groups Effect Size</th>
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<tr>
<td>RISE</td>
<td>$d = .49$</td>
<td>$d = .63$</td>
</tr>
<tr>
<td>ECAU</td>
<td>$d = .37$</td>
<td></td>
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### VLQ: Valued Living Questionnaire

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<tr>
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<th>Between-Groups Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>RISE</td>
<td>$d = .53$</td>
<td>$d = .23$</td>
</tr>
<tr>
<td>ECAU</td>
<td>$d = .47$</td>
<td></td>
</tr>
</tbody>
</table>
Results: Secondary Outcomes

RISE: Within-groups $d = 1.07$
ECAU: Within-groups $d = 1.64$
Between-groups $d = .21$

RISE: Within-groups $d = .49$
ECAU: Within-groups $d = .40$
Between-groups $d = .22$
Higher Satisfaction with RISE Relative to ECAU

Satisfaction with Treatment (CSQ-8)

Cohen’s $d = 1.13$
Perceived Impact

- RISE has empowered me to take much more control over the interpersonal relationships in my life.

- [RISE] opened my eyes and after every session, I would think about what the session was about. When I have a quiet period, I would realize, ‘oh yeah, I do have this quality’ or ‘oh yes, I’ve been able to handle this problem.’ So, it made me see that I wasn’t as awful as I thought I was or as inadequate as I thought I was. It made me realize I’ve accomplished a lot more than I realized.

Veteran-Centeredness & Flexibility of the Intervention

- I got to pick the topic based on what I was going through. That was very good. It helped me to think, ‘okay do I need to focus on this area a little bit more or that area,’ so I liked that I was choosing myself but talking to somebody with expertise at the same time.

- It gave me a chance to figure out where I was currently at in my mental state and where I am at in thinking about what I want with the relationship- not what [provider] thinks I should do. I really liked that. It catered to what I needed instead of ‘this is what we are going to do today regardless of what I feel need.’ So, I liked that.
Discussion & Next Steps

- Results support the effectiveness of RISE in improving empowerment and self-efficacy in women veteran VA patients

- RISE increases valued living and reduces mental health symptoms and IPV to a similar extent as enhance care as usual
  - Robust control condition
  - Qualitative feedback suggests additional benefits of RISE

- Larger more definitive effectiveness evaluation
  - Effectiveness-Implementation Hybrid Type 2 RCT
  - Include men, telemedicine delivery, longer follow-ups

- Ongoing collaboration with VHA IPV Assistance Program
  - Pilot implementation projects with select sites (FY 20 and 21)
  - Updated clinician and patient-facing materials (e.g., gender neutral and more inclusive examples)
  - Addition of a sexual violence module (Megabus) and now up to 8 sessions
  - FY 22: Funds to train IPV Assistance Program Coordinators and provide clinical consultation and implementation support
FY20 RISE Pilot Implementation Project: Program Evaluation Findings
Overview

• Pilot Feasibility Project with IPVAP Coordinators at 5 VAMCs
  – Cleveland VA, Phoenix VA, Albany VA, Durham VA, Bedford VA
  – N=9 providers trained across 5 sites (including 3 psych trainees)

• Self Study of RISE Materials and half-day RISE Training (virtual)

• Consultation (biweekly) for 9 months

• Program Evaluation Data collected via RISE SharePoint
• N=32 Veterans received RISE

• Gender Identity:
  – Woman Cisgender: 84.4%
  – Woman Transgender: 3.1%
  – *Male Cisgender: 12.5%

• Mean Age: 46.3 (SD: 13.0)
  – Age Range: 24-72

• Race:
  – White: 53.1%
  – Black: 21.9%
  – Hispanic/Latinx: 12.5%
  – Asian: 6.3%

*Demonstrates support for the successful application of RISE to male veterans
Pre to Post Change: Routine Care

- Significant increases in self-efficacy with large effect size (Cohen’s $d = 1.3$)

- Significant increases in valued living with medium effect size (Cohen’s $d = 0.6$)

- Significant decreases in depressive symptoms with large effect size (Cohen’s $d = 1.2$)

- High client satisfaction (95% rated intervention ‘Excellent’)
Case Examples from Routine Care Delivery
Birds Eye View of RISE Modules and Sessions
MODULAR-BASED INTERVENTION: TOPIC AREAS

Module A: Safety Planning

Module B: The Health Effects and Warning Signs of IPV

Module C: Improving Coping and Self-Care

Module D: Enhancing Social Support

Module E: Making Difficult Decisions

Module F: Resources and Moving Forward

Module G: Sexual Violence over the Lifespan

Safety Planning
Ways to increase your safety, and that of any children and pets, in different situations, like in an argument or if you are thinking about leaving the relationship through a written worksheet.

The Health Effects and Warning Signs of IPV
Understanding the effects of trauma and IPV on different parts of your life (for example, your physical, mental, and social health, and the well-being of your children). Understanding Warning Signs of IPV, including red flags in partners and the difference between aggressive behavior and assertive behavior.

Improving Coping and Self-Care
Learning about and practicing self-care strategies and ways to relax when you are stressed.

Enhancing Social Support
Learn and practice how to approach friends or family and ask for support.

Making Difficult Decisions
A written exercise that may help you think about your options and make decisions if you are thinking about making a change in your relationship.

Resources and Moving Forward
Learning about resources available in the community for a variety of topics (like housing, employment, legal aid, and restraining orders). Reflect on things you've accomplished and plan ahead for life's ups and downs by identifying red flags to watch out for and ways to RISE up and cope.

Sexual Violence Over the Lifespan
Recognize different forms of sexual violence that are commonly experienced by individuals who experience IPV and make the connection between experiences of sexual violence and health.
SAMPLE SESSION STRUCTURE

**Session Goals:** Brief overview of the main goals for the module

**Estimated Delivery Time:** 45-60 minutes

**Self-efficacy Scores**
- Discuss score on the General Self Efficacy Scale
- *If session 2-8:* Ask about how goal and review module from last visit went; connect with self-efficacy as relevant

**Materials:**
- VA Resources Brochures & Handouts
- Module Handouts

**Session Overview:**
1. Assess whether the Veteran has any concerns for or changes in their physical safety that s/he/they would like to prioritize.
2. Discuss specific module content
3. Goal Setting and Action Planning
4. Assess Readiness to Change
5. Summarize the Visit
6. Next Steps (if appropriate)
HOW DOES THIS RELATE TO OUR CASE EXAMPLE?
FY21: Dissemination & Implementation Activities to Prepare the RISE Intervention for Expansion
Revisions to RISE Manual & Training Materials

- Increased cultural sensitivity
  - More inclusive example throughout (e.g., for LGBTQ Veterans, persons of color)

- Gender neutral terminology throughout
  - Inclusion of examples specific to male and non-binary Veterans
  - Modifications to handouts

- Addition of Sexual Violence Module
  - Responsiveness to Megabus legislation

- Integration of IPVAP guidelines and considerations
  - e.g., assessment, documentation, telehealth
RISE is Inclusive

• Gender
• Age
• Sexual Orientation
• Race/Ethnicity
• Spirituality
• Persons with Disabilities

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• **Definitions and different types of sexual violence, including intimate partner sexual coercion**
  – Improve self-efficacy about using internal and external resources for coping with sexual violence experiences.

• **Common effects of sexual violence**
  – Offer information about the array of mental and physical health problems that can be caused or exacerbated by experiences of sexual violence, including ongoing sexual coercion as well as the cumulative effects of trauma.

• **Coping & self-care strategies**
  • Elicit from the Veteran their interest in exploring some ideas for managing these difficult experiences as they consider their options for support and care moving forward.

• **Exercises and Handouts**
  – E.g., Mindfulness grounding exercises, Sexual health safety planning
Revamped RISE Training

- Updated to include:
  - RISE evidence base
  - MI training videos
  - Role plays and experiential exercises
  - Gender neutral terminology
  - Increased cultural sensitivity

- Full day interactive virtual training
- 6 months of weekly consultation (75% attendance required)
- Completion of 3-4 cases to achieve Provider Status
• 3 VAMCs for scale-out
  – Phoenix VA
    • Site Lead: Kathy Doyle, PhD
    • *May 2021 – current*
  – Cleveland VA
    • Site Lead: Jenny Knetig, PhD
    • *June 2021 - current*
  – Bay Pines VA
    • Site Lead: Maria Taylor, MSW
    • *July 2021 - current*

• Weekly 60-minute consultation for 6 months
• Program evaluation data collection and analysis
• Revise training and consultation program using formative evaluation
FY22:
Next Steps for RISE D&I
Broad roll-out of the RISE program across the entire VA system:

- Conduct 6-8 trainings in FY 22, with 6-8 trainees per training
- Representation from 1-3 VISNs in attendance at each training
- Goal of having representation from each of the 18 VISNs by the end of FY22.
Additional resources

Reference list available on request

Additional questions:

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