Special Report

Fragmented Services, Unmet Needs: Building Collaboration Between The Mental Health And Domestic Violence Communities

An initiative in Chicago is the result of a growing recognition that domestic violence can have serious mental health consequences.

by Carole Warshaw, Ada Mary Gugenheim, Gabriela Moroney, and Holly Barnes

ABSTRACT: The Domestic Violence and Mental Health Policy Initiative (DVMHPI) is an innovative project to address the unmet mental health needs of domestic violence survivors and their children and to develop models that integrate clinical and advocacy concerns. Overseeing a network of more than fifty community-based mental health, domestic violence, substance abuse, and social service agencies, as well as city and state officials, the DVMHPI promotes collaboration and provides training and technical assistance to improve the capacity of local service systems to address the traumatic effects of abuse. This report highlights the importance of generating funding streams that promote collaboration.

This special report describes the Domestic Violence and Mental Health Policy Initiative (DVMHPI), an innovative project designed to build collaboration between domestic violence advocates and mental health providers in Chicago and to develop intervention models that address both clinical and advocacy concerns.[1] The project evolved out of a growing recognition that domestic violence can have serious mental health consequences, yet the systems to which women turn are frequently unprepared to respond to these needs. Although the majority of abuse survivors do not develop psychiatric disorders, victimization by an intimate partner does place women at much higher risk for depression, anxiety, posttraumatic stress disorder, substance abuse, and suicide attempts.[2] Widespread efforts to improve the general health care response to domestic violence have been under way for more than a decade, but there has been no concurrent, systematic approach to domestic violence within the mental health system. Nor have domestic violence advocates developed consistent strategies for addressing the mental health consequences of abuse or the needs of women dealing with mental illness and domestic violence. This lack of collaboration leaves large numbers of women and children without a safe way to address these concerns.[3] It also leaves providers without the necessary resources for doing this complex and difficult work.

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Philosophical Barriers

Historically, advocates have been reluctant to address mental health issues for both philosophical and practical reasons. For example, psychiatric symptoms are generally viewed as understandable responses to terror and entrapment that are likely to resolve with safety and support. Because safety and practical assistance are such critical priorities, programs rarely have the resources to respond to mental health needs. Yet advocates are also wary about addressing mental health issues within their own agencies and compromising their grassroots social-justice focus.

Also, advocates are concerned about the ways that mental health diagnosis and treatment can inadvertently place women in jeopardy and increase abusers' control over their lives.[4] Moreover, mental health services are often not affordable or accessible to battered women—they may not meet eligibility criteria; may not be able to find linguistically competent, culturally relevant services; or may use benefits that are controlled by an abusive partner. Mental health care providers themselves cite lack of training, lack of knowledge about community resources, service restrictions, and funding constraints as barriers to addressing trauma and domestic violence.

The emergence of trauma theory has begun to bridge these differences. Evolving from the experience of Vietnam veterans and rape survivors, trauma theory helped to counter the notion that domestic violence resulted from "women's psychopathology" and instead recognized symptoms as secondary to the effects of victimization. Reframing symptoms as adaptations to intolerable conditions and viewing connection and empowerment as crucial to healing, trauma theory comes closer to advocacy perspectives than previous clinical models did. It also provides a framework for recognizing the impact on clinicians and advocates of doing trauma work. However, given the stigma associated with mental illness and abusers' ability to manipulate public systems, even trauma diagnoses can be used against women when those systems are not informed about trauma or domestic violence.

Systemic Challenges

Over the past twenty-five years domestic violence programs have evolved from a handful of isolated shelters and safe homes to a nationwide network of more than 1,700 agencies supported by well-established public and private funding streams and have generated substantive change in public awareness as well as in the legal and health care arenas. A change in the demographics of women using domestic violence programs has also occurred. As new legal protections expand women's options for safety, shelters are seeing women with fewer resources—women who have experienced greater lifetime adversity and who are in greater need of mental health services—services that are not supported by current funding streams. Social and economic supports are often critical as well.

Likewise, the public mental health system has had to restrict its limited resources to people diagnosed with severe mental illness. Recognizing the pervasive impact of trauma, a number of states have begun initiatives to address the long-term effects of childhood abuse. Until recently, none were focused on domestic violence or on the complications of ongoing abuse. Nor are public systems geared to respond to the traumatic effects of abuse on people who do not meet service criteria. Lack of public funding for mental health services is compounded by the fact that few private foundations fund in mental health, and those that do have not focused on the links between trauma and mental health.

Description Of The Initiative

The DVMHPI bridges this critical gap in services. In late 1999 the Chicago Community Trust's Health Program and the John D. and Catherine T. MacArthur Foundation partnered to support the DVMHPI's efforts to build collaboration between domestic violence and mental health providers. Additional partners include the Michael Reese Health Trust, the Chicago Department of Public Health, the Cook County Bureau of Health Services, and the Illinois Department of Human Services. Some financial support has also

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come from the U.S. Department of Health and Human Services (HHS) Administration for Children and Families and Substance Abuse and Mental Health Services Administration, and the Department of Justice.

The DVMHPI's strategies include (1) promoting collaboration between the advocacy and mental health sectors; (2) developing models for addressing trauma in the context of ongoing domestic violence and facilitating their integration into mental health and domestic violence services; (3) improving access to high-quality trauma treatment that is culturally relevant and sensitive to domestic violence; (4) generating state and federal funding streams to ensure the ongoing availability of resources for training, technical assistance, and service delivery; and (5) influencing public policy to incorporate an understanding of the developmental and intergenerational impact of abuse and violence into a preventive mental health agenda that links early intervention with prevention.

Progress To Date

Since its inception, the DVMHPI has developed a network of more than fifty mental health, domestic violence, substance abuse, and social service agencies. During its first year the DVMHPI conducted an extensive needs assessment through surveys, focus groups, key-informant interviews, and literature reviews. Providers reported high rates of domestic violence, trauma, and mental health needs that were going unmet and large numbers of women who had experienced multiple forms of abuse throughout their lives.[5] Both domestic violence and mental health informants cited gaps in these areas as barriers to advocacy and trauma-informed care: lack of a shared framework, absence of cross-training and collaboration, limited access to services, and inadequate funding. In response to these findings, the DVMHPI searched nationwide for promising initiatives and curricula that could be used or adapted to build capacity both in Chicago and nationally.[6] Project staff also identified key areas requiring new treatment or intervention models.

During its second year the DVMHPI began building collaboration between sectors. Large-scale training sessions raised awareness of the links between domestic violence, trauma, and mental health. Interagency regional working groups collaborated around referral and cross-consultation to varying degrees. Critical-issue groups began reviewing existing trauma treatment models for adults with and without serious mental illness and their children and examining the role of culture and ethnicity in trauma treatment and domestic violence services. Finally, a conference provided basic domestic violence and mental health cross-training and introduced a culturally informed trauma perspective to 300 staffers from seventy Chicago agencies, as well as key city and state domestic violence and mental health administrators.

The positive response to the DVMHPI's framework for integrating culture, advocacy, and trauma perspectives led to the initiative's third-year agenda.[7] The Intensive Trauma Training and Implementation Program (ITTIP) was created in response to participants' requests for more extensive training. Under this program, ten domestic violence programs and nine mental health agencies sent teams for intensive trauma training and agreed to participate in clinical consultations, critical-issue workgroups, and an evaluation. One distinctive feature of ITTIP is its attempt to ensure that all providers are attuned to both adult and child trauma issues; existing models for working with survivors of abuse are often fragmented in this regard.[8]

Results And Lessons Learned

Preliminary results indicate that 94 percent of ITTIP participants have incorporated training into their individual practice and supervisory activities, while 67 percent of mental health agencies and 100 percent of domestic violence programs have begun to integrate domestic violence and trauma-sensitive services agencywide. New assessment tools are being implemented to varying degrees; however, all participating agencies have incorporated into routine practice some form of screening and

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assessment for the presence and impact of domestic violence and other lifetime trauma.[9] Training has also influenced how participants think about their work (that is, incorporating a trauma/advocacy perspective), and for the majority of agencies, information gleaned from training has been integrated into in-service training and client/patient education. Although the training phase was recently completed, ITTIP has initially had a greater impact on transforming awareness and practice in smaller versus larger agencies.

Participants consistently report, however, that effecting more in-depth change will require additional resources, such as more extensive on-site training, technical assistance, or full- time therapist/supervisors with trauma expertise. However, shifts in state politics, staff turnover, and diminishing public funds have created a new set of obstacles. Balancing the initiative's desire to provide resources to the broadest constituency possible with the goals of developing new, high-quality services and generating substantive agency change continues to be a major challenge.

Current Work And Next Steps

In response to these concerns, the DVMHPI is expanding its capacity to offer resources to local agencies wishing to provide services that are sensitive to domestic violence and trauma but lacking the training, expertise, and means to do so. In recognition that isolated training is not enough to change providers' behavior or agencies' practices, strategies are being developed to provide sustained multilevel consultation and training. Current plans are to expand the DVMHPI's Training and Technical Assistance Resource Center to support the initiative's broader outreach endeavors; and direct more focused attention to piloting new intervention models, identifying core competencies, and developing new training curricula.

The DVMHPI is conducting its first targeted pilot project in collaboration with the Chicago Department of Public Health (CDPH) and the Mayor's Office on Domestic Violence. It will create three geographically distributed centers of excellence on trauma and domestic violence. The long-term goal is to train staff at all twelve city-run community mental health centers. Features of this project include referral to mental health services within a day or two for clients from domestic violence programs and possible colocation of domestic violence and mental health services. The CDPH's Department of Epidemiology will conduct an evaluation.

Funding Challenges

Funding this type of initiative brings considerable challenges. First, even minimal staffing has depended on multiple local funding sources, with different grant procedures, nonsynchronized timetables, and varied priorities. Second, from its outset the project was evolutionary, making it difficult to predict what the financial requirements would be once the effort was launched. Third, Chicago has a relatively small pool of health grantmakers, and of those, relatively few routinely support research and policy work, as opposed to direct services.

Finally, since the two service fields involved are largely publicly funded, the project's originators conceived of a long-term funding strategy of trying to institutionalize the work via public appropriations. However, the rapid reversal from surplus to deficit budgets has made sizable state or federal funding more difficult in the near term. Nevertheless, strong commitment to the initiative's overall goals from both public and private funders should sustain it until economic conditions improve and new funding streams can be established.

Policy Implications

The initiative's policy work continues in both domestic violence and mental health. At monthly meetings, domestic violence agency directors and policymakers consider the implications of focusing attention on trauma and mental health for client safety, program integrity, and funding priorities.

For the domestic violence advocacy community, this collaboration has raised issues about how to best address mental health needs (whether related to trauma or not) while maintaining an advocacy focus and ensuring

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that women's experience is not pathologized. A number of questions remain, for example: Is it safer for advocacy programs to train and hire therapists who understand domestic violence? Given limited resources, should programs partner with mental health agencies to develop the types of services they would want women to receive? Can domestic violence programs serve women with more severe mental illness, and, if so, what supports are needed?

For the mental health system, domestic violence raises another set of concerns. The need for mental health services to become informed to address both domestic violence and trauma is clear. Yet stigma, underfinancing, and service fragmentation present formidable obstacles.[10] Without sufficient training and oversight, the risks attending mental health treatment during ongoing domestic violence remain a serious concern—particularly around issues of custody, credibility, confidentiality, documentation, and safety.

On a broader scale, the DVMHPI's activities underscore the importance of reconceptualizing the nature of public mental health services, creating a public mental health safety net, and building partnerships to prevent the continuation of violence and its consequences across generations. This will require the establishment of new local, state, and federal funding priorities; the development, dissemination, and evaluation of new treatment models; and the creation of a new public mental health agenda that emphasizes prevention as well as intervention and that recognizes the high prevalence of abuse among adults and children seeking mental health care.

NOTES

1. For mental health clinicians, advocacy concerns include attention to safety, confidentiality, accountability of perpetrators, documentation, and information about community resources. For domestic violence advocates, trauma perspectives are beneficial in understanding the psychological impact of trauma, destigmatizing responses to mental health issues, and working more effectively with those domestic violence survivors who also have mental health needs. In this report "advocacy" refers to domestic violence advocacy.
2. See J. Golding, "Intimate Partner Violence as a Risk Factor for Mental Disorders: A Meta-Analysis," *Journal of Family Violence* 14, no. 2 (1999): 99–132; J.D. Osofsky, "The Impact of Violence on Children," *Future of Children* (Winter 1999): 33–49; and L.A. Goodman et al., "Physical and Sexual Assault History in Women with Serious Mental Illness: Prevalence, Correlates, Treatment, and Future Research Directions," *Schizophrenia Bulletin* 23, no. 4 (1997): 685–696.
3. Domestic violence is also a serious problem for the lesbian, gay, and transgendered communities, but mental health data on it are still limited.
4. Examples include conducting couples therapy while violence is ongoing, using an abusive partner as a source of collateral information, failing to document a woman's efforts to protect and care for her children, or assigning diagnoses without appropriately linking symptoms to abuse.
5. C. Warshaw, G. Moroney, and H. Barnes, *Report on Mental Health Issues and Service Needs in Chicago Area Domestic Violence Advocacy Programs*, January 2003, www.dvmhpi.org/Publications.htm (7 July 2003).
6. C. Warshaw and G. Moroney, "Mental Health and Domestic Violence: Collaborative Initiatives, Service Models, and Curricula," Working Paper, September 2002, www.dvmhpi.org/Publications.htm (7 July 2003).
7. "Trauma" refers to both individual trauma and the social trauma of poverty and discrimination.
8. Curricula for treating child trauma generally address the impact of recent abuse on parenting but do not focus on parents' own childhood abuse, which could affect their ability to respond to children's trauma-related needs. Adult mental health models rarely focus on parenting.
9. In the past, domestic violence agencies typically tried to screen out women who gave any indication of having a psychiatric diagnosis; now, programs are better able to work with women whom they would have turned away in the past.
10. U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, Md.: DHHS, 1999); and President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, Final Report to the President, July 2003, www.mentalhealthcommission.gov/reports/reports.htm (23 July 2003).

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