Conclusions/Recommendations

There is a relationship between mental illness and domestic violence from all three survey groups – it is clear that the relationship between the recognition, diagnosis, and treatment alternative for co-occurring disorders are evident for all three populations.

Specific recommendations from this data are:

1. There needs to be focused training for Mental Health Practitioners and Victim Advocates:
   - **a.** Mental Health recognition, diagnosis, and treatment alternatives for Domestic Violence Victims
   - **b.** Periodic updates on services and providers for referrals
   - **c.** The prevalence of co-occurrence of disorders with Domestic Violence populations
   - **d.** Community Resources and referral option in the local community – emphasis on the types of services each agency can provide
   - **e.** Legal updates about safety, domestic violence orders, and rights under the law
   - **f.** Expand on training for the recognition of 'other' diagnoses that may occur in treatment (an expanded drop-down list of diagnoses)
   - **g.** Expand training for Mental Health providers on the safety of Domestic Violence victims
2. There needs to be community integration of services with the focus on improving access and filling gaps where no services may be present.
3. Development and implementation of an instrument for the recognition of mental health issues and the potential role it may play for victims of abuse.
4. There needs to be continued emphasis on improving existing services through ongoing training for Victim Advocates and Mental Health Practitioners regarding confidentiality, educational requirements, and state-mandated training requirements for Mental Health Practitioners

These recommendations can be validated by information gathered from the Domestic Violence Listening Project participants.

Their recommendations include:

1. Mental health providers need specific expertise, knowledge and training about the unique needs of victims of domestic violence *(individuals and their families)*
2. Faster response time when seeing a therapist
3. A one-stop shop idea where victims do not have to continually retell their story to one person or group after another
4. Medical physicians need to have better knowledge of referrals to specialists in the area rather than to simply medicate victims as a treatment modality
5. Greater knowledge by mental health practitioners of referral sources in the local area
6. Greater pool of trained therapists so that victims have more access to varying personalities, expertise and experience from a mental health provider
7. Greater emphasis from the mental health community regarding diagnoses – sharing those with clients, confidentiality and treatment
8. Better understanding of mental health diagnoses in relation to medication management, insurance and potential custody issues
9. More services for pre-teens, teens and men who may be victims of domestic violence

ABOUT SHELTER HOUSE

Shelter House is the state-certified domestic and sexual violence center serving victims in Okaloosa and Walton counties. Services provided include 24-hour domestic violence/rape hotline, crisis counseling, advocacy, outreach, primary prevention, transitional housing and confidential shelter.

If you feel that a family member or intimate partner is endangering your physical or emotional safety or if you know someone experiencing this in their home, call Shelter House's hotline at **1-800-44-ABUSE**, or **850-863-4777**.

ABOUT COPE

COPE is the Chautauqua Offices of Psychotherapy and Evaluation, Inc., a private, not-for-profit community mental health center in Walton County. The Center offers a comprehensive array of quality mental health and substance abuse treatment services, including outpatient counseling, adult residential services, prevention education, psychiatric treatment, crisis counseling, case management, screening and referral and wellness programming for all ages. The **24-hour Help Line is 850-892-4657**.

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This report was compiled by the Multidisciplinary Collaborative Planning and Development Team from the surveys and analysis authored by David Schjott, Ed.D.

Shelter House
Domestic & Sexual Violence Center

COPE Center
Renewing Our Community Through Counseling, Care and Compassion

Shelter House
Domestic & Sexual Violence Center

THE INTERSECTION OF MENTAL ILLNESS & DOMESTIC VIOLENCE:

An Analysis of Services in Okaloosa and Walton Counties

Women who have suffered some form of victimization are at greater risk for post-traumatic mental health episodes which may include substance abuse, anxiety, depression, sleep disruption and poor coping strategies.

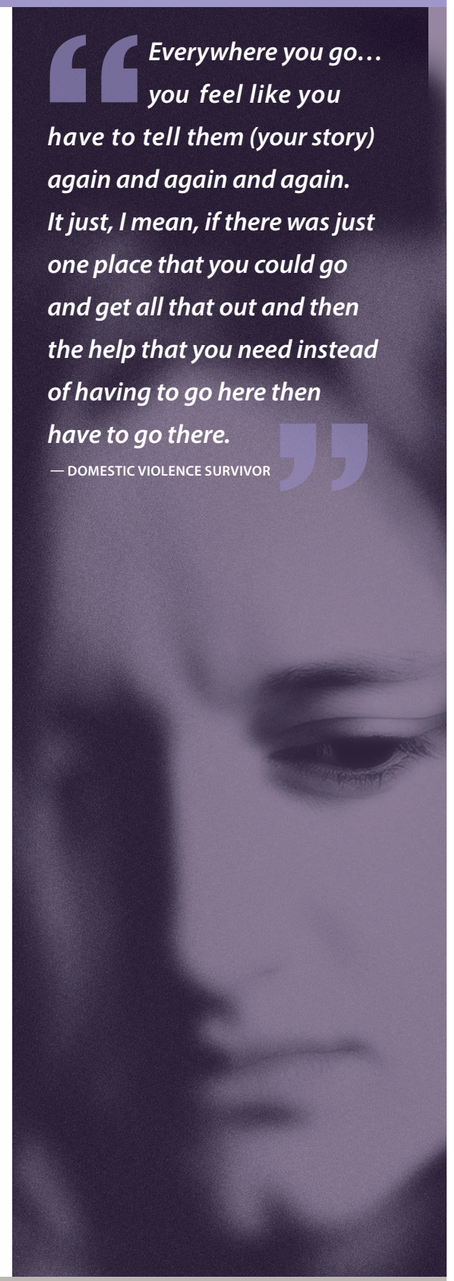
Mental health practitioners should be proactive in developing skills related to violent risk assessment because a lack of specific knowledge about intimate partner violence may result in giving the abusers the ability to manipulate the victim and undermine their credibility and ability to address their mental health needs appropriately.

Shelter House, Inc., a not-for-profit center serving domestic and sexual violence victims and survivors in Okaloosa and Walton Counties, Florida, in partnership with COPE Center (Chautauqua Offices of Psychotherapy and Evaluation) in Walton County, Florida, formed a collaborative partnership to determine and define current service needs in the local community for domestic violence survivors with mental health issues. Together the partnership would like to develop a collaborative response when addressing the complexities of co-occurrence of domestic violence and mental health issues and address the unique barriers victims and survivors face related to seeking mental health services. The collaboration between community domestic violence advocates and mental health providers is important on many levels. Some victims may feel safe in an advocacy environment while others may prefer a mental health environment. Thus, if clinicians and advocates are able to develop the trust and understanding necessary for good working relationships, they will better be able to help battered women to traverse those boundaries and to be safe, to heal and to move forward with their lives.

Three separate and distinct surveys were designed to gather data regarding the suspected "gap" between mental health services and the needs and demands of domestic violence assessment and support. Surveys were given to mental health providers in Okaloosa and Walton counties and Shelter House victim advocates. Domestic violence survivors participated in listening groups designed to offer specific recommendations from the victim's perspective.

Both quantitative and qualitative data was gathered in this research. The aim of the data was to: 1) gain greater insight into the collaborative commonalities between domestic violence victims, advocates and mental health providers; 2) to access where there may be 'shortcomings' or missed opportunities for training and advocacy in the local/regional communities; and, 3) to identify concerns or barriers to care for those in need.

As a result of this study, all three groups identified that a relationship between the two exists, that better training and education would be beneficial and that recognition of these relationships is critical for successful outcomes. In addition, the greater examination of the co-occurrence of disorders should lead to improved services, more robust outcomes and other educational opportunities for growth and community success for all involved.



DID YOU KNOW?

BETWEEN **60%** AND **90%** OF VICTIMS HAVE HAD EPISODIC EVENTS WITH **MENTAL ILLNESS** IN THEIR LIVES. THE AUTHOR ALSO FOUND THAT **81%** OF WOMEN WHO HAVE BEEN TREATED FOR **PSYCHIATRIC DISORDERS** REPORT HISTORIES OF ABUSE.
WARSHAW (2001)

STUDIES IN THE UNITED STATES AND CANADA REVEALED **RATES OF DEPRESSION** RANGING FROM **17%** TO **72%** AND RATES OF **POST-TRAUMATIC STRESS DISORDER** (PTSD) RANGING FROM **33%** TO **88%** IN WOMEN RECEIVING SERVICES FOR DOMESTIC VIOLENCE.
WARSHAW (2001)

Data Results

*31% OF AMERICAN WOMEN REPORT BEING **PHYSICALLY** OR **SEXUALLY ABUSED** BY A HUSBAND OR BOYFRIEND AT SOME POINT IN THEIR LIVES.

*30% OF AMERICANS SAY THAT THEY KNOW A WOMAN WHO HAS BEEN **PHYSICALLY ABUSED** BY HER HUSBAND OR BOYFRIEND IN **THE PAST YEAR**.

*THE COST OF INTIMATE PARTNER VIOLENCE EXCEEDS **$5.8 BILLION** EACH YEAR, **$4.1 BILLION** OF WHICH IS FOR DIRECT MEDICAL AND MENTAL HEALTH CARE SERVICES.

MENTAL HEALTH PRACTITIONERS SURVEY

Among the mental health practitioners surveyed, 83% responded yes and 16% responded no when asked if they currently see individuals in abusive relationships in their daily practice as a therapist. They responded that refer those individuals to local service organizations. The practitioners reported seeing depression, anxiety disorders, and post-traumatic stress disorders (PTSD) as common diagnoses and believe that victims often stay in abusive relationships because of a cycle of behavior or codependence.

This survey revealed that 39% of mental health practitioners who responded would offer couples therapy when they deem it appropriate, even when domestic violence/abuse is an issue. However, in a domestic violence situation, this can be extremely dangerous and is never considered appropriate among domestic violence professionals. When mental health practitioners were asked if they could identify and address the immediate needs of a client who is in danger as a result of domestic violence, 94% said yes and 6% said no.

Of the respondents who said they would provide couples therapy, statements regarding their choice to offer the service included: "I am trained, experienced and understand domestic violence"; "only if the violence has stopped"; "only if there has not been an arrest for domestic violence"; "if it can help the victim not feel alone"; and "it is a part of family therapy; require a safety contract". One respondent stated that they usually do not provide therapy, "so it would have to be a special case" while another respondent stated that only if "past abuse and client was getting help with substance abuse".

Of those practitioners stating that they would not do couples therapy, the responses included: "I would refer to someone with expertise"; "not appropriate for our agency"; and "individual therapy for the victim first". Other responses included issues such as "clients need intervention prior to couples therapy" while others cited issues such as "safety concerns" and an "increased danger risk". One respondent stated that there needs to be individual therapy first to establish safety, and another stated that "a no contact order needs to not be in place prior to therapy".

Depression (67%) was the most common mental health diagnosis given to individuals seeking mental health services who are in abusive relationships. Bipolar disorders were the second-most diagnosed (50%) followed by other (22%), substance use disorder (17%), borderline personality disorder (6%) and anger issues (6%).

When asked to diagnose or explain why an individual would abuse their partner, 53% suspected substance use disorder, 35% said anger issues, 24% said anti-social personality disorder, 18% said depression, 18% said other issues, 12% said post-traumatic stress disorder and 6% said borderline personality disorder.

Regarding why a victim would most likely return to an abusive partner, 61% stated that the client is stuck in a cycle of behavior that most often prevents them from leaving. Codependent behavior (44%) was the second most common response, followed by other (22%), addictive behavior or addiction (17%), emotional instability (17%) and substance use disorder (6%).

> *"My therapist told me, 'If you love your husband then you can bring him in here and we can work on your marriage'. I don't think that he (the therapist) understands domestic violence if he is saying that."*
> — DOMESTIC VIOLENCE SURVIVOR

Mental Health Practitioners were asked if they would do couples therapy when domestic violence/abuse is an issue

39% SAID *YES*

SHELTER HOUSE VICTIM ADVOCATES

Victim advocates recognize mental illness with the women, children and men that they serve. Advocates felt most comfortable working with individuals with depression, PTSD and anxiety disorders. They had the most difficulty with bipolar disorder and borderline personality disorders.

Victim advocates felt the most comfort with addressing mental health issues and the potential barriers to treatment such as recognizing the need for further assessment (60%); addressing the subject of mental health (80%); helping victims to seek services (80%); recognizing potential barriers to services (80%); and the role of medication management in treatment (80%).

One-third of the victim advocates surveyed had the least amount of comfort in recognizing mental health as a potential issue.

Fifty-three percent of respondents showed a low level of comfort with their knowledge of available community resources for mental health, while most victim advocates had the greatest comfort level with confidentiality requirements with 73% scoring this item at 6 or above on a 10-point scale; 27% scored this a perfect 10 on the scale.

DOMESTIC VIOLENCE LISTENING GROUPS

Shelter House and COPE felt it was imperative that they include the voices of the domestic violence survivors in this process. Victims believed that mental health practitioners need much greater specific knowledge about victims, intervention, treatment, referrals and management of cases. Sensitivity and unique circumstances also need to be addressed, as in the case of the recommendation of couples therapy as an intervention.

Obstacles to seeking out mental health services included long wait times, access to mental health services specifically for domestic violence and access to more counselors in the area. One participant stated that the recognition of services by the Shelter House victim advocate was of vital importance: "… if it hadn't been for her, I probably wouldn't be sitting here right now. Because there was some more mental health that came in after that. And I went and had to be an inpatient for a while recently." Another challenge that was identified in the group was the difficulty repeatedly retelling their story. Participants identified medical doctors as another issue. They both felt as if doctors addressed mental health issues simply with medications. "He wanted to like pump me full of it, but I wanted to feel something to try and get through it."

All participants stated that their interactions with mental health providers were generally good, but problematic issues involved clicking with a particular therapist, the therapeutic style and switching therapists throughout the course of treatment due to layoffs or people changing positions within the organization.

Several of the participants felt as if the therapist at Shelter House had a good understanding about issues and concerns of domestic violence: "But when I came here (Shelter House) it was, it was like immediate. She met me right where I was, you know". They did not have that same feeling about other mental health providers in the local area. One stated that "the person was just too aloof …not right on key, you know". Another stated that a therapist made told her "if you love your husband then you can bring him in here and we can work on your marriage. I'm like, did I not just tell you that you just – that's a safety risk. I don't think that he (the therapist) understands domestic violence if he is saying that". In addition, participants stated that they were comfortable in asking questions about their diagnosis. One participant said that she would never ask and that she was never given a specific diagnosis by her therapist. Another participant stressed the need for confidentiality of the diagnosis, cautioning to "be cautious of forms that list your abuser as a contact". Also, HIPPA (Health Insurance Portability and Accountability Act) was an issue. A specific mental health diagnosis "could be used against you in a custody hearing".

Some noted the lack of specific knowledge of the therapist about domestic violence, pointing out that the therapist lacked maturity and seemed to be too clinical. They also stated that there are not enough mental health providers with specific knowledge about domestic violence in the area.

Participants were asked what they would do if they could change the mental health providing system. One participant stressed the need to have private agencies with no affiliations with the military bases. Other suggestions included the need for more specific services for children and adolescents, more flexibility with time and scheduling and therapists with more expertise with the unique issues of domestic violence.

Other suggestions by the group included more advocacy and services for young girls who may be in abusive relationships. In addition, more service geared toward men was also mentioned.

> *"If it hadn't been for my victim advocate, I probably wouldn't be sitting here right now. Because there was some more mental health issues that came in after that."*
> — DOMESTIC VIOLENCE SURVIVOR

80% of the victim advocates felt most comfortable with their basic understanding of depression.

MOST OFTEN USED REFERRAL SOURCES: