

ACKNOWLEDGING THE INVISIBLE: INTEGRATING FAMILY VIOLENCE INTO MENTAL HEALTH SERVICES



INTRODUCTION

Family Violence as a Public Health Issue

Long considered a “private trouble,” family violence has not been recognized--until recently--as the public issue that it truly is. It has only been in the last fifteen years that domestic violence has been declared as a public health issue by former Surgeon General C. Everett Koop (Mercy, Rosenberg, Powell, Broome & Roper, 1993), a sentiment later echoed by former U.S. Secretary of Health and Human Services Donna Shalala, who decried the “epidemic of violence sweeping across our nation (1993),” and followed most recently by David Satcher in his *Report of the Surgeon General*, who proclaimed domestic violence to be a “serious and startlingly common public health problem with mental health consequences for victims... and for children who witness the violence (1999).” Yet while public health as a profession is just beginning to acknowledge that domestic violence not only exists, but is a problem underlying many health conditions, the field of mental health still has not yet done likewise.

For decades, the societal solution to domestic violence has been relegated to a criminal justice response, coupled by a “patch ‘em up and send ‘em home” mentality by medical providers who blamed the victim for the abuse and labored only to fix the broken bones, all the while ignoring the broken hearts and wounded spirits of those affected by the brutality. Moreover, the concern (what little there was) has remained focused on physical abuse and its resulting injury; little or no attention has been paid to the effect on the psyche of the victim, or on the children who had been present when the violence occurred. Mental health professionals labelled women who dared to speak of their domestic violence experience as “paranoid” or “histrionic,” and then prescribed a regimen of tranquilizers to aid their adaptation to their abusive home environment.

Thankfully, much has changed in that regard: physicians are becoming trained to identify abuse, law enforcement officers and district attorneys’ offices are working in concert to prosecute those responsible, and counseling is offered to victims of domestic violence in a variety of settings.

Yet the provision of mental health services for domestic violence victims and survivors remains limited in a number of ways, primarily: funding (or lack thereof); unwillingness to embrace domestic violence as a major risk factor for, or contributor to, the development of mental illness; and the underlying assumption that once a victim has passed through the initial crisis stage at the time of separation from the abuser that the abuse indeed stops, coupled with the minimization or outright denial of the long-term effects of domestic violence on both its direct and collateral victims.

Intersection of Domestic Violence & Mental Health Issues

For far too long, the mental health community has ignored the intersection of family violence and mental health. Not only are mental health services rationed, limited only to the most severe cases, but the co-occurrence of mental illness and family violence remains unacknowledged and unaddressed even among professionals who know it intuitively to be true. It is clear the mental health profession recognizes the co-occurrence of mental illness and substance abuse, and the contributory effect one has on the other. Specialized programs have been developed to address the problems of the dual diagnosis population, legislation has been drafted to indicate that this is a high priority in service delivery, and multiple new funding sources have poured millions into serving the unique needs of this population. Parallel to this, however, is the issue of the co-occurrence of family violence and mental illness: but there are no innovative services offered to this troubled population, no funding sources, no legislative priority, no acknowledgement that it is indeed even an issue.

Yet virtually every case of multiple personality disorder can be traced back to horrific child abuse, incest, domestic violence, or rape trauma. Histories of victimization are similarly common with borderline personality disorder, attachment disorders, and paranoia. Depression and suicide, both priorities in terms of mental health services, are often predicated by the client's experiences of family violence which remains largely disregarded by mental health professionals. Both victims and perpetrators often resort to substance abuse as a means of ameliorating the pain, and yet the addiction itself is the focus of treatment. But to look at the diagnosis and to ignore the root cause is both unethical and unprofessional, particularly for social workers and others who have been trained to see beyond the diagnosis into the contributory circumstances at the mezzo and macro levels. Yet the individual practitioners are not to blame: it is the lack of services, the myopia of the profession that focuses solely on the designation of serious mental illness, and the indifference of the public at large to not demand services which are both sensitive and clinically appropriate to those who have been victims of interpersonal trauma.

Mental Health Effects of Family Violence

Long Term Effects of Abuse in Children

Long-term effects of child sexual abuse have been identified in the areas of self-esteem, personal power, emotional expression, sexuality, intimacy, body awareness, childbearing, and parenting (Spies, O'Neil, & Collins, 1998). It would not be illogical to assume that many of the same issues would be of similar importance to adult victims of similar abuse.

Long term effects have been identified in child witnesses to domestic violence, particularly the high incidence of Post-Traumatic Stress Disorder (PTSD). In Helene Berman's (1999) comparison of children of battered women and child refugees of war, significant similarities were found, including sadness, anger, confusion, and PTSD. Berman concluded, "these studies provide convincing evidence that the effects of violence exposure are not transient or temporary but may endure over many years (p. 60)." These same effects have been observed in adult abuse victims as well as children (Raphael, 1998; Walker, 1979).

In child sexual abuse victims, Lanktree & Briere (1995) demonstrated both short- and long-term effects: anxiety and post-traumatic stress dissipated much more quickly than did anger, dissociation, and sexual concerns which were not resolved completely. There is every reason to believe that long-term effects would be observable in adult abuse victims as well, although surprisingly few studies have been published on the subject.

Many of the children who meet the diagnostic criteria for Serious Emotional Disturbance (SED), come from homes in which they witnessed domestic violence, or they themselves were abused. Children in abusive homes suffer serious cognitive, behavioral, emotional and developmental impairments which significantly alter their lives (Jaffe, 1990). In addition, school-aged children who have witnessed domestic violence are prone to poor academic performance, constant fighting with peers, and rebellion against adult authority (National Center on Women and Family Law, Inc., 1994). Adolescents raised in an abusive environment are dramatically more likely to be runaways, to engage in teenage prostitution, or other delinquent behavior; to be prone to substance abuse or suicide attempts, and to commit sexual assaults (Commonwealth of Massachusetts, Department of Youth Services, 1985). In Oregon, 68% of juvenile offenders in treatment programs had witnessed the abuse of their mother and/or were subjected to abuse themselves (Rhoades & Parker, 1981). Studies show that in 50-70% of the cases in which a parent abuses another parent, the children are physically abused as well (Bowker, 1988). Moreover, many male children experiencing domestic violence grow up to become abusive in adulthood (Hotaling & Sugarman, 1986).

Long term effects in adults

Koss, Goodman, Browne, Fitzgerald, Keita & Russo (1994) reviewed long-term effects observed in adult victims of domestic violence including intense startle reactions, tension, nightmares, chronic fatigue, disturbed sleeping and eating patterns and medical symptoms (van der Kolk, 1987; Davidson & Foa, 1991; Herman, 1992; Goodman, Koss, & Russo, 1993a). Moreover, some survivors remain passive, withdrawn, and continue to display apathy and symptoms of depression (Chapman, 1962; Peterson & Seligman, 1983). Dehart proposes also that a survivor's ability to trust and to form emotional attachments is severely impacted by domestic violence (1996). Bard & Sangrey suggest that normal recoveries may take months for victims of crime (1986); but while some survivors exhibit little pathology immediately following the trauma, extreme symptoms may develop years later in response to major life stressors (van der Kolk, 1987). Ellis, Atkeson & Calhoun (1981) found that rape victims experienced consistently higher levels of fear and anxiety compared to controls for as long as 16 years after the rape occurred.

Walker's ground-breaking work with battered female victims identified depression, feelings of low self-esteem, helplessness, and generally severe stress reactions coupled with somatic complaints. A study of women who had been victims of long-term emotional abuse identified PTSD symptoms, along with depression and dissociative forms of coping (Raphael, 1998).

In the last two decades, several studies found that a large portion of the psychiatric emergency services and institutional inpatients were, in fact, battered women (Jacobsen, 1989; Herman, 1986; Hilberman & Munson, 1977). Domestic violence is strongly associated with depression, anxiety, somatization, attempted suicide, and chemical abuse (Jaffe, Wolfe, Wilson,

& Zak, 1986; Kemp, Rawlings, & Green, 1991). Yet the mental health problems experienced by these victims is directly attributable to the abuse they endured, and were not the cause of the violence (Roberts, Williams, Lawrence, & Raphael, 1998).

Psychological abuse frequently has a far more detrimental effect on abuse victims than physical abuse, (Raphael, 1998; Heise, et. al, 1999), and often leads to self-doubt, depression, and confusion, and may severely limit a victim's ability to assess options that may aid him or her in leaving the abusive relationship. (Sackett & Saunders, 1999). Furthermore, Sackett & Saunders explain that victims of long-term abuse may experience numbing and suppression of feelings that may take several years to uncover and heal. Survivors of family violence often experience difficulty in future relationships, which affects not only the stability of home and family, but also professional relationships in the course of employment. Moreover, many former abuse victims are challenged with issues surrounding housing, substance abuse, and poverty, in addition to the sequelae of victimization. Domestic violence is a major cause of homelessness: one study found that 50% of homeless women and children in one county were fleeing their abusive homes (Burstein & Woodsmall, 1987).

HISTORICAL BACKGROUND & CONTEXT

A Short History of Family Violence in America

Earliest records documenting domestic violence date back to 753 B.C. (Dobash & Dobash, 1978), and are traceable throughout every historical period (Pleck, 1987). Puritans from England brought with them to the American colonies patriarchal views (Pagelow, 1984), and women and children were regarded as the property of the husband (Blackstone, 1899). Patriarchal privilege was codified into law when the courts considered it reasonable that a man should be able to "beat his wife with a rod no thicker than his thumb (Dobash & Dobash, 1978)." The Declaration of Sentiments, penned at the Seneca Falls Convention in 1848, recorded women's difficulty in obtaining a divorce from an abusive husband, child custody issues, and wife abuse (Pleck, 1987).

The Christian Women's Temperance Movement, responsible for prohibition, originally began out of concern that men's "chastisement" of women became particularly brutal when the husband was under the influence of alcohol. Since societal apathy around the issue of violence against women and children afforded them no protections legally or otherwise, and because drunkenness was considered the single cause of wife beating, it was hoped that the prohibition of alcohol would end family violence. It was a hopeful but misguided notion.

In 1910, wife abuse was considered illegal, but was not punished as a crime (Gordon, 1988); although most states would grant divorce on the grounds of cruelty. However, courts were more concerned about a husband's drunkenness and foul language around the children than their witnessing his abuse of their mother (Gordon, 1988). From the late 1800's to the 1970's, the issues of battered children eclipsed those of abused wives. In the mid-70's with the resurgence of feminism, the first battered women's shelter in America opened, and activism to criminalize domestic violence resulted in over half of the states providing for orders of protection for abused women (Schechter, 1982). Still, there was little public outcry against domestic violence until the well-publicized murder of Nicole Brown Simpson in 1994. The Violence

Against Women Act which followed (P.L. 103-322), provided federal funds for the creation of a national domestic violence hotline, increased funding for domestic violence shelters, increased federal penalties for repeat sex offenders, restitution provisions for victims (this provision has since been overturned by the Supreme Court), and the creation of federal penalties for interstate domestic violence. VAWA also encouraged policies to mandate arrests for batterers, rights for battered immigrants to petition for residency, and training for rural judges on crimes against women (Schechter & Edelson, 1999). No funding was provided for medical or mental health services in the Act.

Mental Health Approaches To Abuse

In the mid 1890s, Pierre Janet and Sigmund Freud, rivals researching hysteria, both determined that it was a psychological condition induced by trauma (Herman, 1997). Janet (1889) called the unbearable emotional reactions of his patients “dissociation,” a term still used today. Both researchers acknowledged that the somatic symptoms their patients suffered was the result of repressed memories of trauma, and could be relieved by recovering the traumatic memories and the intense feelings which accompanied them through focused discussions with the patient (Herman). While both researchers utilized the “talking cure,” Freud followed intensely the “thread of memory,” uncovering patients’ histories of rape, abuse, and incest. He became noteworthy when he dared to publish his findings of eighteen case studies in *The Aetiology of Hysteria*, a compassionate treatise on the effects of child sexual abuse (Herman). However, his fame brought him scorn and placed his practice in jeopardy, as the patients he was treating were being sexually abused by their fathers and uncles, who did not look kindly upon his exposing their escapades. He quickly recanted, and while he continued to follow a line of questioning in psycho-analysis that centered on sexuality, he ignored the exploitative context in which these relations occurred (Herman). By the beginning of the twentieth century, he had concluded that his patients’ accounts were simply untrue and could be attributed to fantasy (Freud, 1925).

Since that time until now, denial of the existence of abuse and its attendant effects remains deeply embedded in the mental health profession, as has the tendency to blame the victim for the abuse rather than holding the perpetrator accountable. A 1964 study entitled “The Wife-Beater’s Wife” describes the course of treatment of a domestic violence victim. The researchers determined marital violence fulfilled the women’s “masochistic needs,” and that personality flaws in the victim were the cause of the problem, so they sought to treat her by persuading her that she had caused the violence. Her “treatment” was considered successful when she no longer refused to submit to aggressive sex when her husband was drunk, and no longer tried to protect herself from beatings (Snell, Rosenwald & Robey, 1964).

Mental health clinicians have done a disservice to survivors of trauma by their inference that certain personality traits might predispose her to abuse, just as they have by the assumption that survivors should be ordinary, well-adapted and healthy people after they have endured such abuse. Herman, a psychiatrist who has worked with abuse survivors for over twenty years, delivers this scathing indictment of the mental health profession:

Chronic abuse causes serious psychological harm. The tendency to blame the victim, however, has interfered with the psychological understanding and diagnosis of a post-traumatic syndrome. Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the abusive situation to the victim's presumed underlying psychopathology (1997, p. 116).

One might wish hopefully that the profession has grown more compassionate and understanding since the sexist "treatment" study in the sixties, yet less than twenty years ago a group of male psychoanalysts proposed that "masochistic personality disorder" be added to the revision of the Diagnostic and Statistical Manual (DSM) in the mid 1980's. This diagnostic label was to be applied to one who "remains in relationships in which others exploit, abuse, or take advantage of him or her, despite opportunities to alter the situation." Because of the outcry of organized women's groups, the proposed diagnosis was changed to "self-defeating personality disorder," and the diagnostic criteria was likewise changed such that it would not be applied to victims of abuse, and was buried in the appendix, where it remains to this day (Herman, 1997).

There are some within the mental health profession that realize that abuse carries with it a legacy of trauma that can result in personality changes, mental illness, and post-traumatic stress disorder (PTSD). However, as a profession overall, it has yet to differentiate that the panic disorders, phobias, anxieties and depression of abuse survivors is markedly different than ordinary phobias, anxieties and panic disorders which are not based in fact or traumatic experience, as they are in abuse survivors (Herman). Mental health professionals, on the whole, operate from the absurd assumption that domestic violence survivors will go on with their lives without the benefit of compassionate and sensitive treatment specific to their abuse, and expect normalcy from them. A medical provider would not expect a dislocated hip to resolve itself without intervention and appropriate care, yet the mental health profession has imposed similar unrealistic expectations of survivors of chronic and personalized abuse.

The profession itself has yet to speak the unspeakable truth that abuse does exist and that it fractures the psyche of its victims, as the profession is ill-prepared to treat them. The mental health service delivery system has yet to acknowledge the invisible thread of victimization that underlies mental illness. The profession has followed in the footsteps of the Father of Psychology by denying the reality that sexual, physical and psychological oppression were, and are indeed endemic, even among the respected and affluent in society. Like Sigmund Freud, mental health professionals have ignored their pain, minimized their horror and pathologized the victim.

The Current Mental Health Service Delivery Structure in California

State legislation created the Short-Doyle program in 1957 to establish a county-based mental health delivery system. The voluntary program did not elicit the intended response initially, and the funding formulas went through multiple revisions to achieve their current state: 90% of the outpatient program is funded from state funds, and 10% from the county coffers;

85% state funds and 15% county funds for inpatient services in an attempt to maximize less-costly outpatient services. The state's version of federal Medicaid (Medi-Cal) was enacted in 1966 to provide mental health services on a fee-for-service (FFS) outpatient basis by private providers. The Short-Doyle/Medi-Cal program took shape in 1971, in an attempt to allow counties to obtain a 50% federal match for providing mental health services to Medi-Cal eligible clients. This funding system split Medi-Cal into two delivery systems: the fee-for-service Medi-Cal (FFS/MC) system, which utilized solo practitioners (usually psychologists and psychiatrists); and the Short-Doyle/ Medi-Cal (SD/MC) program, which utilized the services of trained social workers, marriage and family counselors, and ancillary therapists in a clinic-based setting at a significantly reduced cost (California Mental Health Planning Commission, 2001). The current level of funding is estimated to be less than half of the amount required to provide basic services to the mentally ill population, having reached its dismal levels after a succession of devolutionary reductions in funding, driven by radical economic declines from the 70's through the early 90's (Goodwin and Selix, 1998).

When FFS/MC and SD/MC were consolidated, a "medical necessity" rule was applied to access mental health services. The medical necessity provision for inpatient care under Section 1820.205 requires a specified diagnosis in the DSM IV (Diagnostic and Statistical Manual, 4th edition) requiring psychiatric inpatient services attributable to certain behaviors or symptoms. The outpatient medical necessity delineation was outlined in Section 1830.205 as one having a DSM IV diagnosis resulting in significant impairment and probable deterioration. Moreover, eligible care must be focused on the impairment (i.e., suicide attempts), not the cause (i.e., domestic violence) or any contributing factor (e.g., substance abuse); the patient must be amendable to treatment; and any conditions that will not respond to treatment must be referred to medical intervention. Such limitations are particularly problematic when applied to the complex intersections of domestic violence, mental illness, and substance abuse.

Realignment, an act of legislative and fiscal genius enacted in 1991, was envisioned as a method of "guaranteeing" health and mental health services, by establishing a local revenue fund from sales tax and a portion of vehicle licensing fees. This constant funding base allowed for more stable service delivery, by removing funding from the discretionary state General Fund. This legislation also specified the target populations to be served, centering on serious mental illness. Realignment was then followed by the move toward a managed mental health carve-out for Medi-Cal services to refocus services from an episodic basis to planned service delivery in an effort to provide more effective and coordinated care (California Mental Health Planning Commission, 2001). Counties are still liable to provide safety net services to those ineligible for Medi-Cal, but since there are no funding sources available to reimburse counties, such services are rationed only to acute crisis care and stabilization.

Moreover, the legislation limits these services "to the extent resources are available," a slippery slope which legitimizes the rationing of mental health care. Currently, the Department of Mental Health operates under a "freedom of choice" waiver, renewed every two years by the Health Care Financing Administration (HCFA), which allows California' county mental health plans to limit choice of providers to the defaulted county plan as long as it can ensure access and quality of care (California Mental Health Planning Commission, 2001). However, by limiting patient choice, the county mental health plans are simultaneously limiting their service delivery

to seriously mentally ill clients exclusively, and are contractually and fiscally barred from developing early intervention and prevention services through this funding mechanism.

The Landscape of Current Domestic Violence Services

Currently, domestic violence victims have only a circumscribed array of services available to provide mental health services specific to their experience of abuse. The current mental health service delivery system for victims and survivors of domestic violence is a patchwork of unrelated services which is typified by a lack of resources, a lack of access, a lack of funding, and a lack of expertise.

Lack of resources.

Domestic violence services, for the most part, are available only in times of acute crisis. Mental health services to address the long-term effects of abuse are simply not available in most cases. Victims (but not family members or other concerned parties) may obtain short-term counseling services from a shelter or domestic violence agency, which is often based on a sliding fee scale, and is frequently restricted to the acute transition phase, when one is seeking escape from the abuser. Long-term counseling to aid the victims in processing, recovering and transcending the abuse are virtually nonexistent. While these acute crisis services are necessary and beneficial, they do not meet the full scope of mental health service need for victims: there is a definite intersection between victimization and mental illness, and the staff of domestic violence agencies are, on the whole, unprepared to deal with clients with co-occurring mental illness. Additionally, domestic violence agencies must often turn away clients with severe mental illness and substance abuse, as their staff are usually non-clinicians.

Lack of access.

Private counseling services are available, yet until recently mental health services were not a covered benefit by most insurance policies, and the out-of-pocket costs of therapy make it prohibitive for all but the wealthiest of domestic violence victims. Victim/Witness Assistance offers reimbursement for medical and counseling services required as a direct result of the crime, however, there are many potential barriers: the client must agree to cooperate with police and the district attorney in the prosecution of the case (which often puts the victim in more danger); reimbursement for services is limited to a maximum lifetime cap of \$10,000 for counseling for the primary victim (\$3,000 maximum cap for immediate family members and children); victims can only qualify if they have applied within one year of the time of the crime; and the application forms are available only in English, and Victim/Witness has only limited bilingual/bicultural staff to aid in translation for the completion of the application. Battered immigrants and undocumented victims do not qualify in many cases, and many victims often find themselves unable to comply with the uncompassionate and uncompromising bureaucratic barriers to this funding.

Lack of funding.

Funding sources for domestic violence agencies are, in most cases, tied to shelters, which limits their focus to the acute crisis mode. County mental health clinics are likewise extremely limited in their current offerings of services to victims and survivors of domestic violence, as well as to children exposed to family violence. Part of this is due to the funding mechanisms

driving the service delivery; Medi-Cal eligibility is an absolute requirement for reimbursement to the counties for services rendered. If the client is deemed ineligible for Medi-Cal, due to financial limits or immigration status, the client remains unserved, unless the client is experiencing an acute crisis—say, suicidal ideation (or actual attempts) as a result of abuse—in which case they can be seen, but only for stabilization. Moreover, in all but acute crisis cases, a previous diagnosis of mental illness (of a specified level of severity) is required to obtain services at all.

Lack of expertise

A lack of expertise exists on the part of mental health providers to adequately deal with the sequelae of abuse; a corresponding lack of mental health expertise on the part of domestic violence service providers compounds the problem. Moreover, domestic violence agencies cannot possibly serve all the victims requiring services: there are often cultural, religious and language barriers to effective service delivery; victims of abusers who are employed in law enforcement frequently cannot avail themselves of services, as the need for confidentiality is often compromised; also, many victims are hesitant to call a domestic violence agency due to misperceptions that they are all run by militant feminists; their hesitancy is fueled by societal indifference to the victimization of women and children.

Furthermore, all of the above resources are limited to serving only the victim and the children exposed to domestic violence, and none (except Victim Witness and private counseling paid out-of-pocket) cover the family members of domestic violence victims who are often also affected. Additionally, all are subject to rigid time and/or eligibility constraints; yet the need for counseling for domestic violence victims often exceeds the time limit, (again, except private therapy, which is frequently limited to a specified number of visits by insurance plans).

The resulting impact of this lack of service delivery is an increased number of inpatients in institutions due to domestic violence, elder abuse, and child abuse. The fragmented services and lack of a safety net inevitably ends up with domestic violence/mental health patients recycling in and out of crisis, which adds to the trauma they have experienced, drives up cost, and leads to poorer outcomes.

MAIN ELEMENTS OF THE PROPOSED POLICY

Similarities Between Mental Illness And Domestic Violence

Domestic violence and mental illness have several things in common:

1. Without adequate and timely intervention, they both can (and do) result in preventable deaths.
2. Both are heavily enshrouded in stigma.
3. Both are inadequately funded.
4. Service delivery in both is limited primarily to address acute crises only.

Just as the mentally ill end up in jails because of limited treatment options, so have family violence victims been locked away into psychiatric wards, rather than providing them the

necessary counseling to enable them to heal from their traumas and move on to healthier and more productive lives.

The Intent of the Policy

The three-fold intent of the policy is to integrate domestic violence expertise, care, and service into the mental health service delivery system; to recognize it as a major contributing factor to mental illness, and to make resources available to fund appropriate care.

Populations At Risk

The populations at risk impacted by this service gap are, firstly, domestic violence victims and survivors (whether identified or otherwise); secondly, children exposed to domestic violence; thirdly, family members of the victim; fourthly, perpetrators; and lastly, the society at large. The overall impact on at-risk populations is expected to result in increased mental health services initially, decreased mental illness and increased functioning of survivors, collateral victims, and perpetrators of abuse.

RECOMMENDATIONS FOR CHANGE

The restructuring of mental health services to adequately meet the needs of Californian survivors of family violence rests on three main recommendations:

I. Build internal capacity within the mental health profession regarding family violence

- a. Provide cross training of mental health professionals and domestic violence advocates, batterer's intervention providers, staff from Social Services, Department of Alcohol and Drugs.
- b. Establish a minimum knowledge base of domestic violence as a standard for all practicing mental health professionals.
- c. Widespread information dissemination throughout the profession.
- d. Work to provide universal access to mental health services for all family violence victims, both primary and collateral.

II. Develop statewide leadership on the unacknowledged intersection of family violence and mental health/illness

- a. Governor to appoint a domestic violence advocate to form the Family Violence/Mental Health Advocacy Commission.

- b. Governor to assign Mental Health staff to all 58 domestic violence councils in the state by Executive Order to promote integration and collaboration.
- c. Influence the mental health profession on domestic violence treatment standards and best practices, such as the recommendations against couples therapy in cases of ongoing domestic violence (Brannen & Rubin, 1996).
- d. Family Violence/Mental Health Advocacy Commission to sponsor legislation to revise the W & I Code on eligibility and resources; establish pilot programs; Create a Family Violence Mental Health Services Fund (FVMHSF) for the unsponsored, those ineligible for Medi-Cal or for Victim/Witness reimbursement.
- e. Reallocate existing resources: redirect a portion of marriage license, divorce fees to FVMHSF; redirect unspent Victim /Witness funds on an annual basis to the FVMHSF; establish perpetrator fines upon domestic violence, rape, murder, or child abuse convictions to be paid into the fund; seek other funding sources to establish safety net services.
- f. Foster collaborations with organizations on the federal, state and local levels to promote integrated services to better address the needs of survivors and collateral victims.

Locally, such collaborations would include: Domestic Violence Councils, Child Abuse Councils, Social Services Agencies, Probation Departments, courts, Public Health Departments, Mental Health Departments, churches, ethnic identity groups, consumer groups, mental health contract providers, Children’s Shelters, domestic violence shelters, batterer’s intervention programs, Police Departments, insurance providers, EAP programs, local NAMI chapters (National Alliance for the Mentally Ill), Mental Health Advisory Programs (MHAPs), Mental Health Boards, consumer/client groups.

State collaborations would include: California Coalition Against Domestic Violence, State Department of Mental Health, California Mental Health Planning Council, the Little Hoover Commission, the California Mental Health Directors Association, California Medical Association, managed mental health organizations, Medi-Cal managed care organizations, insurance providers, EAP programs, the state NAMI chapter, therapist associations (NASW, APA, CMA, etc).

Federal collaborations would include: National Council of Juvenile & Family Court Judges, Office of Violence Against Women, Center for Mental Health Services (CMHS), National Institutes of Mental Health (NIMH), DHHS (MediCal Office), HCFA (Medicare office), NAMI.

- g. Incorporate domestic violence into the mental health research agenda, by lobbying CMHS, NIMH to allocate funds for research into the intersection of family violence, mental illness, substance abuse, and the need for mental health services for survivors.

III. Develop a system of community care to serve all ages across the lifespan

A. In general

1. Promote coordination; integrate mental health services into the existing domestic violence community care system.
2. Ensure that domestic violence is a component of the training for Crisis Intervention Teams on mentally ill suspects.
3. Provide technical assistance for batterer's intervention groups, domestic violence agencies, probation, courts on mental health needs of clients, and cultural competency in service delivery; assessments.
4. Develop clear Memorandums of Agreement regarding information sharing and client confidentiality in joint service models of domestic violence and mental health services.
5. Provide crisis debriefing services for the community after domestic violence incidents.

B. Improve the Children's System of Care relative to Family Violence

1. Add domestic violence services to "necessary services" language determining eligibility for SED population.
2. Understand that SED problems can arise from domestic violence, domestic violence services a component of wraparound programs.
3. Appoint a mental health professional to sit on child abuse review teams and intervention plans regarding custody and visitation in domestic violence cases to be consistent with the child's mental health needs.

C. Improve the Adult/Older Adult System of Care relative to Family Violence

1. Provide mental health services for victims without a maximum or lifetime cap, understanding the long-term effects of domestic violence (not to overlap with services provided by domestic violence agencies in acute transition phase).
2. Work collaboratively with victims' families to provide mental health services as necessary in dealing with the sequelae of abuse.
3. Provide in-services for staff at SNFS, IMDS, and A/OA administration on domestic violence and elder abuse: mandate effective and sensitive screening as well as reporting.

SUGGESTED INTERVENTION STRATEGIES

Implementation of the recommendations center on four main leverage points: coalition building, proposed legislation, education and training of mental health professionals, and development of funding sources.

Coalition Building

Once the governor has appointed an advocate and the Domestic Violence/Mental Health Advocacy Commission is formed, its tasks would be to first develop by consensus the group's mission, vision, and goals; the second task would be to lobby the interest and endorsement of the State Department of Mental Health, the Little Hoover Commission, California Mental Health Planning Council, SAMHSA's Center for Mental Health Services (CMHS), National Institute for Mental Health (NIMH); then to identify a legislative champion who will propose new legislation; fourthly, to host a mental health provider summit for managed mental health care organizations and private insurance companies with the anticipated outcome of each voluntarily revising their mental health benefit structure regarding family violence, using the recent parity law as leverage. Lastly, the Commission should hold a summit for graduate schools of psychology and social work who are preparing future mental health professionals with the anticipated outcome of their voluntarily revising their curriculum to include family violence identification and treatment throughout the human lifespan.

Proposed Legislation

The proposed legislation (the Family Violence and Mental Health Services Act) would declare the legislature's intent to integrate domestic violence services into the mental health services delivery system and to promote the development of a comprehensive and collaborative service network to provide care, safety, and mental health services to victims and survivors of family violence. It would then remove insurers' time limitations on mental health services for domestic violence victims and expand services beyond acute transition phase, and would likewise prohibit lifetime caps on mental health services related to the long-term effects of the abuse. Moreover, the Act would expand services to others (family, friends) affected by domestic violence as a mandated area of coverage by all insurance providers.

In light of the Little Hoover Commission's recommendation that "no one who needs care should be denied access to services," the Act would amend the Bronzan-McCorquodale Act (W&I Code 5600.3) first by removing the phrase "to the extent resources are available," which rations care; and secondly by adding in language to W&I Code 5600.1, "as well as those suffering from the effects of family violence or related trauma" to provide access to survivors who do not meet the narrowly-defined target as it is currently. The new language would read as follows: "The mission of California's mental health system shall be to enable persons experiencing severe and disabling mental illnesses, and children with serious emotional disturbances, *as well as those suffering from the effects of family violence or related trauma* to access services and programs in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports..." Likewise, Section 5600.2b, which defines the target population to be served, would be revised as follows: "Persons

with serious mental illnesses *and histories of family violence* have severe, disabling conditions that require treatment, giving them a high priority for receiving available services.”

Finally, the Act would create a Family Violence Mental Health Services Fund (FVMHSF) for the financing of mental health services for those ineligible for Medi-Cal, Victim/Witness, and the unsponsored, to establish safety net services for family violence survivors without pilfering funds for services for the seriously mentally ill, through creative funding strategies to be explained later.

Education & Training of Mental Health Professionals

To ensure that future mental health professionals are prepared adequately, graduate schools of psychology and social work will be lobbied to revise their standard curriculum to include domestic violence, child abuse and elder abuse--to not only recognize and report, but to treat both in acute stage and in long-term.

Likewise, professional organizations will be approached to require domestic violence training as a condition of continued licensure, and a domestic violence training model will be developed to be delivered at professional conferences for those currently practicing. In this manner, domestic violence expertise will be infused into the mental health workforce within the next five years.

Development of Funding for Mental Health Services

The services and outreach strategies recommended in this document will require resources for the following purposes: for mental health services for at-risk populations, for integration of community care, for training of mental health professionals in the system, for staffing at state level for mental health/domestic violence advocate, and to support the Commission’s lobbying and organizing efforts. Potential Resources include possible demonstration grants from these federal sources: Office of Criminal Justice Planning (OCJP), Office of Violence Against Women, Office for Victims of Crime, Center for Mental Health Services, National Institutes of Mental Health, US Dept of Justice, Department of Health & Human Services, and VAWA funds. Private foundations such as the David & Lucile Packard Foundation, and conversion foundations such as the California Wellness Foundation, the Health Trust, and others may be approached as well.

If consultation fees are collected for cultural competency and assessment services provided to batterer’s intervention and domestic violence programs, they may be diverted to the FVMHSF. Additionally, other funding streams would be developed to enhance the fund by establishing defendant fees: a surcharge on Emergency Protective Orders, Restraining Orders, no-contact orders; and perpetrator fines upon domestic violence, rape, murder, or child abuse convictions to be paid into the fund. These would aid in demonstrating batterer accountability while providing much-needed services for victims. Existing resources will be reallocated by redirecting a portion of marriage license and divorce fees, as well as unspent Victim /Witness funds to the FVMHSF on an annual basis.

SUSTAINING THE POLICY DIRECTION

Several of the strategies discussed thus far will serve not only in the establishment of the policy, but in perpetuating it as well. Once corporate and federal funding sources are cultivated, they often become permanent fixtures in the budget. Additionally, once the effectiveness of California's pilot program is demonstrated, it will serve as a model for the nation. Media advocacy and continued policy advocacy efforts can further entrench it into the societal consciousness. Articles on mental health issues caused by family violence published in peer-reviewed journals can keep the issue alive for clinicians, as can professional conferences on the topic. Furthermore, once the federal bodies CMHS and NIMH adopt the research agenda, it is virtually assured that research on the intersection between domestic violence and mental illness, long-term effects of family violence, and other related endeavors will follow in universities, foundations, and institutions throughout the state.

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