
Mental Health *and* Domestic Violence:

***COLLABORATIVE INITIATIVES,
SERVICE MODELS,
and CURRICULA***

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Introduction

Developing Collaborative Partnerships Between Domestic Violence Advocates And Mental Health Providers In Order To Provide Comprehensive Services For Domestic Violence Survivors and Their Children

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It has long been recognized that victimization by an intimate partner has serious psychological consequences. However, collaborative models for addressing these issues have been slow to develop. This is due in part to the different perspectives of domestic violence, mental health, and substance abuse service providers, and to the lack of an integrated framework that addresses both the social and psychological needs of battered women and their children.

Collaboration between domestic violence advocates and mental health providers is important on many different levels. For individual battered women who may initially seek help in either system, having a provider who helps them assess their needs and who provides access to a full range of resources can only enhance the quality of care they receive. As some women will feel safer and more connected with a mental health provider, others will feel more comfortable in an advocacy environment. 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 in their lives.

Collaboration is important for providers as well. Mental health clinicians are less likely to feel overwhelmed by women's need for safety or their need for help negotiating the legal system if they are working in partnership with domestic violence advocacy programs. At the same time, having a network of clinicians who can assess the mental health needs of a domestic violence survivor and/or her children, provide treatment, or help negotiate the mental health system will only enhance the capacity of domestic violence programs to address the needs of the women they serve.

It is essential to create and make available collaborative treatment and service delivery models that reflect the social and advocacy needs as well as the psychological concerns of battered women and their children - models that address the traumatic sequelae of both past and current abuse. The authors have spent several months investigating the existence of such models and have found that they are relatively few in number. Moreover, most that do exist have not performed evaluations to test for efficacy or effectiveness, due in part to financial constraints and to program-focused, rather than research-focused, priorities. The exceptions to this tend to occur in the context of well-funded demonstration grants, such as the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Women, Co-Occurring Disorders, and Violence Study.

In the first section of this report, *Concerns of State Domestic Violence Coalitions* and *Concerns of Mental Health Providers and/or Agencies* are described. The information in these sections emerged in the process of gathering information from State Domestic Violence Coalitions, State Mental Health Departments, community collaborations, individual programs, and from practitioners and experts across the country. The report then describes *Model Initiatives and Programs* that have already begun the work of examining and responding specifically to the mental health needs of battered women and their children. Many of these models are broadly conceived to respond to the mental health needs of trauma survivors in general, a group which includes survivors of domestic violence as well as survivors of other types of trauma, such as rape and childhood sexual abuse. Finally, the report reviews a number of well-respected training curricula that could be utilized or adapted to prepare advocates and mental health/substance abuse providers to respond to the complex needs of battered women and their children who are struggling with trauma-related mental health concerns.

Concerns *of* State
Domestic Violence Coalitions

Four key themes emerged in conversations with directors and staff of State Domestic Violence Coalitions. *First, many Coalitions reported an increasing awareness of the need for services that address the concerns of women with mental health and/or substance abuse problems.* As legal protections for battered women improve, women with greater resources are less likely to utilize domestic violence shelters. Increasingly, shelters are seeing women with the fewest resources - i.e., low-income women, immigrant women, women who have been multiply-victimized as children and as adults. These are women who have experienced greater adversity throughout their lives, and who may be more vulnerable to the mental health consequences of abuse. Coalition informants commented that many shelters and agencies, already struggling with limited resources, feel unprepared to respond to the complex needs of the women they serve. There is also a growing awareness among domestic violence advocates of the need to address the traumatic effects of domestic violence on children and to provide longer-term services to support women in the community once they leave a shelter setting.

Second, tensions have emerged within the advocacy community over the increasing professionalization of domestic violence staff in what has historically been a grassroots/peer-support movement and the potential jeopardy women may be placed in if mental health issues are formally addressed. For example, many advocacy groups are concerned about the implications of hiring clinically trained staff to provide domestic violence advocacy and counseling because of the potential for both creating professional hierarchies and for replacing an advocacy-based empowerment model with clinically-based approaches and interventions. While many programs do hire staff with professional degrees, more often than not, these staff function as advocates rather than as clinicians. Programs report, however, that clinically trained staff members are more likely to recognize mental health needs and make referrals to mental health providers. In addition, a number of domestic violence agencies have hired or contracted with clinicians (MSWs, substance abuse counselors, psychologists, and, in a few instances, psychiatrists) to provide both assessment and treatment for mental health and/or substance abuse problems. Programs that have gone this route report being pleased with these arrangements.

Yet, routine mental health assessment of women entering domestic violence programs remains a controversial topic. While many agencies screen for mental health problems, formal mental health assessment is not the norm, since women generally seek services to address safety rather than mental health issues. Moreover, mental illness is still highly stigmatized and is frequently used against battered women in child custody decisions by abusers as well as by the legal and child welfare systems. Advocates expressed concern that conducting mental health assessments, in addition to changing the nature of advocacy-based programs might alienate and endanger battered women.

A third set of issues centers on the general apprehensiveness of the advocacy community toward working with mental health providers. In many instances, this apprehension is based on past unsuccessful attempts at collaboration and on negative experiences with the mental health system that battered women have described. Some coalition informants reported experiences with mental health providers who have not recognized the limitations of their own training in preparing them to understand and respond to domestic violence. Coalitions also expressed concern that mental health approaches to domestic violence (e.g., diagnosis, medication, couples counseling) can be pathologizing, create special risks for women and their children, and fail to capture and respond to the social underpinnings of abuse. Finally, many coalition representatives commented that mental health professionals minimize the importance of advocacy work.

Lastly, coalitions see an urgent need for resources that will help them address these issues. For example, without exception, coalitions asked questions about the kinds of tools and supports *DCPP/DVMHPI (Developing Collaborative Partnerships Project/Domestic Violence and Mental Health Policy Initiative)* will provide, and expressed their eagerness to receive reports, recommendations, training materials, and model protocols as soon as they become available. Several state coalitions report that they are planning to begin dialogues with mental health and substance abuse service providers on issues central to this Initiative and are seeking materials that will assist them in this process. A number of individual programs are also looking for guidance on how to improve their

responses to domestic violence survivors who have experienced multiple forms of abuse across their lives. A major goal of DCPD/DVMHPI is to help bridge the philosophical and service delivery gaps between the domestic violence and mental health communities and to provide some of the practice, policy, and training resources necessary to enhance and speed these efforts.

**Concerns *of* Mental Health
Providers *and/or* Agencies**

An additional set of issues emerged in conversations with mental health providers, agency administrators, and mental health officials. Consistent areas of concern included:

- the lack of resources available to the public mental health system
- the limitations that managed care places on clinicians' ability to provide trauma-related mental health services.

Furthermore, while many community mental health providers expressed a desire to understand how to work better with domestic violence programs, they also voiced frustration at the difficulties they anticipate in adding new services to already under-funded systems. In several states the departments of mental health have developed or are in the process of developing initiatives to integrate trauma-related services throughout their public mental health systems. While not all of those initiatives specifically address domestic violence, it is seen as an important concern. However, the interest in and ability to address trauma-related issues clearly varies from state to state.

A second area of tension involved the difficulties that mental health and substance abuse providers, even those whose work specifically focuses on women, have historically had in working with domestic violence programs. This has been, in part, due to many of the issues described above in addition to the differing priorities among programs. While many advocates and clinicians do share a common set of overall health and safety goals for battered women, the focus of interventions and the principles that guide them are often quite different. Clinical interventions are generally geared toward treating the consequences of abuse, while advocacy-based interventions focus on helping women mobilize the resources necessary to achieve safety and on changing social conditions that perpetuate abuse. Clinicians expressed frustration that some advocates view mental health treatment as inherently problematic. Some advocates feel that needing "treatment" implies that something must be wrong with the woman, and that clinicians often ignore the fact that what needs to be fixed is a society that tolerates domestic violence. Such a view leaves no avenue for addressing the very real mental health consequences of abuse or the very real issues faced by women dealing with other mental health concerns. Trauma theory, by emphasizing what has *happened to* a person rather than *what is wrong with* the person, provides an important bridge.

Trauma-oriented clinicians, however, were quite aware of the crisis-oriented focus necessitated by battered women's immediate safety, housing, economic, and legal needs. These immediate needs historically have prevented domestic violence programs from addressing longer-term recovery and support issues. Although providers from all three sectors do recognize the convergence of domestic violence, substance abuse, and trauma-related mental health issues, often one issue, depending on the setting, is seen as central, and the others are viewed as secondary problems that will resolve once the primary issue is addressed. While this often reflects the particular orientation of a given program, it may also be a reflection of how women prioritize their own needs. There are, however, several programs that are developing more complex models for addressing the full range of women's concerns.

Collaborative Initiatives *and* Programs

A small number of model initiatives around the country attempt to understand and respond to the complex mental health and substance abuse service needs of battered women and their children. As previously noted, some initiatives are broadly intended to address the needs of trauma survivors. Generally speaking, these efforts fall into three categories: (1) model statewide policy and/or training initiatives, (2) model local/regional collaboratives, and (3) model direct service programs or networking initiatives.

**Collaborative Statewide Policy
and/or Training Initiatives**

A number of states have begun to address the mental health needs of domestic violence survivors with regard to statewide policy and/or training initiatives. In a few states, efforts specifically designed to address domestic violence and mental health were initiated by advocates, government agencies and/or state domestic violence coalitions. Some coalitions, notably those in South Carolina, Missouri, West Virginia, and Maryland, report recently formed interdisciplinary working groups or committees that are examining the intersection of domestic violence, substance abuse, and mental health from the perspectives of various human service delivery systems. Most of these committees are in the early stages of development and just beginning to engage in organized collaborative activities; exceptions are detailed in this report.

In several other states, responses to domestic violence have been incorporated into state mental health trauma initiatives whose original objectives were to address the long-term sequelae of childhood abuse and other lifetime trauma. Some of these initiatives have included domestic violence coalitions from the outset; others are just beginning to focus attention on this issue. In yet other states, efforts to include domestic violence programs have met with resistance and trauma initiatives continue to center on adult survivors of childhood abuse, many of whom also experience domestic violence. Several additional states have developed initiatives relatively recently (e.g. Connecticut, Maryland, Missouri, New Hampshire, Oregon, South Carolina and Texas) that are not reflected in this report, either because they are still new or because they do not specifically address domestic violence. Many statewide trauma initiatives are directed specifically toward people diagnosed with severe mental illness; others are designed to serve a broader constituency. Most, at least initially, have targeted the needs of adult survivors rather than of children who witness or experience violence.

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An initiative is underway in Hawaii to provide cross training to domestic violence, sexual assault, mental health, and substance abuse service providers. Organized and supported by the Hawaii State Commission on the Status of Women, the Na Wahine team was initially convened to organize, plan, and deliver training on domestic violence to health care providers throughout the state. The interdisciplinary team has been expanded to include representatives from the public sectors of health, criminal justice, and the judiciary, as well as sexual and domestic violence, mental health, and substance abuse agencies throughout Hawaii. Na Wahine Team members represent both the ethnic diversity and rural/urban mix of the state. Training activities have been expanded to include service providers and community professionals working in the area of violence against women.

In March 2000, the Na Wahine Team sponsored a statewide conference attended by almost 300 people on medical issues related to domestic violence. In October 2001, the team sponsored a conference for almost 400 participants that examined the many ways women experience violence in their lives. The purpose of the conference was to improve delivery of services to racial, cultural, ethnic, and language minorities in Hawaii. The conference brought together mental health, domestic violence, and substance abuse service providers, criminal justice personnel, policy makers, and community members from Hawaii, the continental United States, Canada, Asia, and the Pacific.

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Kentucky has one of the few statewide initiatives to address the mental health system's response to domestic violence. In 1985 the state of Kentucky created a Sexual and Domestic Violence Program within the Department of Mental Health; then, in 1995 Governor Patton established the Governor's Office of Child Abuse and Domestic Violence (GOCADVS). Run by a clinician (Carol E. Jordan, M.S.), the office has provided cross-training on mental health, substance abuse, and domestic violence to a wide array of clinicians and agencies, particularly therapists within Community Mental Health Centers. Additionally, office staff co-authored an article in *Hospital and Community Psychiatry* (now the *Journal of Psychiatric Services*) to provide guidelines for community mental health centers on how to respond to domestic violence (Jordan & Walker, 1994). They have also developed a curriculum for training mental health providers on domestic violence.

In 1996, the Kentucky General Assembly passed legislation mandating training on domestic violence for health and mental health professionals. To fully implement the legislation, the office has developed a comprehensive training manual on domestic violence for mental health providers that addresses the safety and legal contexts that affect the lives of domestic violence survivors and their children, parts of which are available online (*Mental Health Interventions in Cases of Domestic Violence, 1998*). In conjunction with their mental health professional associations, this training has been offered to thousands of mental health professionals in Kentucky. In a further supplement to the training efforts, the office also reaches out to mental health professionals-in-training by providing symposiums and teaching coursework at local universities. Finally, office staff provide training to mental health professionals on "compassion fatigue" or "secondary trauma" related to providing direct services to victims and their families.

GOCADVS has also worked to set up and develop specialized clinical programs, a strong network of Rape Crisis Centers in Kentucky, an Office of Women's Health and Mental Health within the state's Cabinet for Health Services (which includes within its focus the impact of violence on women) and a strong legislative presence. A Legislative Task Force on Domestic Violence, created in 1994, conducted a survey of mental health professionals providing treatment to domestic violence offenders by way of a court order (Jordan, 1996). The Task Force found a lack of consistency across programs, a dearth of providers, and a lack of attentiveness to issues of dangerousness. These findings led to legislation creating a statewide certification program for mental health professionals who provide court-ordered domestic violence offender treatment.

In addition, a subcommittee of GOCADVS is examining offender treatment certification programs to address quality issues and considering the creation of a "forensic mental health certification board." Such a board would combine offender treatment certification with an existing certification program for mental health professionals who treat sex offenders. It is considering proposing legislation to mandate the collection of outcome data by offender treatment providers. The Office is also working with the University of Kentucky to explore the feasibility of creating a forensic mental health institute to train mental health providers in how to conduct their clinical work in ways that protect the safety of women and children, particularly when legal issues may be involved.

Finally, the office is involved with the University of Kentucky in conducting research on violence against women and related outcomes for victims. A stalking study has already been completed, a sexual violence study is in preparation, and office staff are developing a research project on “compassion fatigue” or “vicarious traumatization” among therapists and advocates who provide services to victims of domestic and sexual violence.

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Efforts have been underway in Maine for a number of years to address the needs of trauma survivors within the public mental health system. In 1995, the Office of Trauma Service (OTS) was formed to provide leadership and consultation for the Maine Department of Mental Health, Mental Retardation, and Substance Abuse and its contract agencies. Maine was the first state to formally address these issues and under the auspices of Dr. Jennings has played an important role in assisting other states to develop trauma agendas. Informed by a statewide needs assessment involving mental health service consumers and providers, the OTS developed a strategic action plan to achieve four principal goals:

1. the formation of stakeholder networks and public education initiatives;
2. the development of trauma-based treatment options, services, and supports;
3. education and training of service providers; and
4. the creation of state policies supporting the provision of adequate systemic and programmatic response to the clinical and support needs of traumatized clients.

The first priority of the Maine initiative is ensuring that the group of individuals within their system who are in greatest need – those with the most serious and persistent mental health and/or substance abuse problems, the majority of whom experienced severe childhood trauma, including exposure to domestic violence – receive trauma-sensitive and trauma-appropriate treatment for issues that have largely gone unaddressed. When individuals served by the mental health and substance abuse systems do experience domestic violence, efforts are made to consult with domestic violence advocacy programs and to learn from their expertise. Although addressing domestic violence has not been the primary focus of this initiative, both the Maine Coalition to End Domestic Violence and the Maine Coalition Against Sexual Assault are now part of the state’s Trauma Services Implementation Team and are involved in a model pilot project to create trauma-informed services in two community mental health centers. Representatives from the Office of Trauma Services and the Maine Commission on Domestic Violence and Sexual Assault also work together on a number of government committees, including a committee charged with addressing domestic violence and mental health issues. Initially, domestic violence programs had been reluctant to participate in this Initiative, in part because their resources and services have been geared

toward addressing the pressing safety, legal, and housing needs of battered women rather than trauma that occurred in the past.

A number of Maine's organizing strategies could be useful to other states attempting to develop a collaborative approach to addressing the traumatic effects of domestic violence in the context of lifetime abuse and to integrate trauma-informed domestic violence services throughout a range of state systems. These strategies include:

- A Trauma Survivor Action Network consisting of groups of consumer/survivors that meet regularly throughout the state for an ongoing dialogue about informed advocacy and peer support.
- A 24-hour trauma support line housed in a sexual assault program.
- Trauma support groups that meet at sexual assault advocacy programs for women and men who have survived sexual abuse and experience mental health and/or substance abuse problems.
- Implementation of statewide training and supervision in trauma-based assessment and treatment. Training in trauma has been made a core competency for all state employees with direct care responsibilities, and a cadre of trauma trainers has been created to provide regular continuing trauma education to contract agency and state staff.
- Trauma clinical consultation services (that provide funding for addressing special needs of abuse survivors through their providers) operate in all three regions of the state. Allocated funds are used to pay for services such as case consultation, trauma assessment, diagnostic testing, and second opinions.
- Emerging evidence-based and promising treatment approaches such as the Community Connection Trauma, Recovery and Empowerment model, the Sidran Risking Connection model, and the Dusty Miller ATRIUM model have been introduced and implemented at several agencies across the state.
- Specialized newsletters, bibliographies, provider resource lists and Internet listservs, and public education publications have been produced and distributed.

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In May, 2000, the NYSOMH created a Trauma Unit in its Chief Medical Office, signaling the high priority of routine trauma assessment and treatment in New York's public mental health system. The unit is an outgrowth of the agency's Trauma Initiative that began in 1995. The Trauma Initiative is a multi-pronged effort to improve the response of the public mental health system to individuals diagnosed with serious mental illness who are trauma survivors. The original focus of this endeavor was to improve mental health services to consumers who had been sexually abused as children. Currently, efforts are being made to address the needs of domestic violence and sexual assault survivors as well.

To achieve its goals, the Trauma Initiative combined statewide leadership with a local organizing strategy. Following the distribution of an OMH statement on the needs of trauma survivors and a plan of action, the Trauma Initiative then took the following steps to develop local leaders. It:

- Directed each state psychiatric center to begin a Trauma Workgroup.
- Established an electronic bulletin board to disseminate information.
- Funded a nonprofit agency to facilitate the development of local trauma networks including mental health, rape crisis, and domestic violence program representation.
- Partnered with the Conference of Local Mental Hygiene Directors, representing New York State's local mental health systems.
- Supported local clinical training programs.

To date, the accomplishments of the Trauma Initiative include:

- Receiving priority status for state funding of about ten new programs and/or positions.
- Holding six annual training conferences, the last of which drew over 1,100 clinicians and recipients.
- Making trauma training mandatory for state psychiatric center staff.
- Getting trauma screening forms included in the new automated case record.
- Persuading many state hospitals and local programs to offer trauma-related educational and skill-building groups.

The strategies utilized by the NYSOMH Trauma Initiative could be adapted to include issues specific to domestic violence.

***Domestic Violence, Mental Health, Substance Abuse, and Disabilities Subcommittee: Professional Education Committee of the North Carolina Domestic Violence Commission
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www.doa.state.nc.us/doa/cfw/cfw.htm**

In 1999, North Carolina's Governor's Task Force on Domestic Violence delivered its final report that included a series of policy, practice and funding recommendations on how the state should improve its response to domestic violence. One of the recommendations was to establish a permanent Domestic Violence Commission to coordinate and oversee the state's response and to implement the 44 recommendations made by the Task Force. Among the committees established as part of the Commission's structure, was the Professional Education Committee, which was charged with working on recommendations regarding professional training needs. The Committee established a subcommittee to work on the issues of mental health, substance abuse, and disabilities as they relate to domestic violence. The subcommittee's work plan is to address the professional training and educational needs of these professional communities and to identify "best practices" related to assessment and treatment in the mental health, substance abuse, and disabilities' systems and practices.

The committee is composed of representatives from local mental health agencies, the North Carolina Office on Disability, the statewide health education agency, the Area Health Education Center (AHEC), the state Department of Health and Human Services, the North Carolina Coalition Against Domestic Violence, local colleges/universities, and public health professionals. It is currently evaluating model policies and protocols for screening, documentation, and treatment. The committee is also compiling results of surveys administered to private and governmental mental health, substance abuse, and disabilities programs located in North Carolina. The survey attempts to document the level of training and use of protocols for assessment and treatment. Committee members are also compiling results of surveys administered to universities and colleges throughout the state to ascertain whether students in schools of social work, pastoral counseling, criminal justice, psychology, and other disciplines are receiving core instruction on domestic violence. The data will then be used to develop model policies, protocols and screening tools, in addition to professional training and educational curricula on domestic violence for mental health, substance abuse, and disabilities communities. These materials will be made widely available across the state.

***Rhode Island Domestic Violence and Mental Health Cross Training: Rhode Island Coalition Against Domestic Violence and Rhode Island Department of Mental Health, Retardation and Hospitals
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Over the past several years, the state of Rhode Island has held yearly cross-training conferences to address the mental health, substance abuse, and advocacy needs of domestic violence and sexual assault survivors. Although this collaboration has been limited to training and has not specifically addressed service delivery, domestic violence programs in Rhode Island, as in many other states, have developed individual relationships with mental health providers in their communities. Part of the impetus behind the cross-training efforts was the recognition by both the Director of the Department of Mental Health, Retardation and Hospitals and the Director of the State Domestic Violence Coalition of the overlapping needs of women they serve. Both commented that this recognition might have been due to the fact that each had worked in the other system at some point in their careers. This type of crossover work experience has influenced other collaborative endeavors across the country.

***Restoring Connections Training Conference and Study Commission: Vermont Network Against Domestic Violence and Sexual Assault
Montpelier, Vermont***

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A policy initiative underway in Vermont focuses on the capacity of the community mental health system to respond effectively to trauma survivors, including survivors of domestic and sexual violence. A training conference served as a catalyst for statewide efforts at systems change. Recognizing that survivors of trauma who experience mental health and/or substance abuse problems are largely disconnected from their communities, and that mental health and substance abuse service providers are disconnected from domestic violence and sexual assault advocates, in 1999 the Vermont Network Against Domestic Violence and Sexual Assault worked with partners to plan and co-host the *Restoring Connections* conference. The conference was primarily intended for (and attended by) clinicians from the mental health and substance abuse service systems. The conference aimed to do two things: (1) re-frame the mental health sequelae of abuse into advocacy concepts of power and control, and (2) lay the groundwork for systems change that empowers trauma survivors.

The Vermont Network Against Domestic Violence and Sexual Assault, together with activists in the community mental health movement, began a dialogue with supportive members of the Vermont legislature about the need for adequate and effective services for trauma survivors. As a result, Vermont passed legislation for a study commission that examined the need for improved services for trauma survivors with mental health and substance abuse problems. The multidisciplinary study Trauma Commission included representatives from the following groups and agencies: mental health consumers and survivors of domestic and sexual violence; the Vermont Network Against Domestic Violence and Sexual Assault; the community mental health centers; Vermont's Office of Developmental and Mental Health Services; Medicaid and private insurance; and the Veteran's Administration. The Trauma Commission generated a lengthy report and the following recommendations:

- Designate one place within state government from which to coordinate trauma-related training, policy, and services.
- Increase professional training opportunities to prepare service providers to work more effectively with trauma survivors.
- Increase clinical and support services.

Since that time, Vermont's Agency for Human Services has begun to implement a statewide Trauma-Informed Service System, based on recommendations by Harris and Fallot.¹ Plans have been developed for a number of departments, including Mental Health, Social Welfare, Aging and Disabilities, Health, Corrections, Vocational Rehabilitation, Social Services and Child Welfare.

¹ Harris, M. and Fallot, R. (2001). Using Trauma Theory to Design Service Systems. *New Directions in Mental Health Service*. San Francisco, CA: Jossey Bass.

***Crossroads Training Conference and Trauma Workgroup
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In 1999, a coalition of mental health consumers, trauma survivors, and providers from the mental health, domestic violence, substance abuse, and sexual assault service systems participated in the *Crossroads Conference*. This conference grew out of many efforts in Wisconsin to address the issue of mental health and other services for survivors of abuse and/or trauma. The conference, which was co-sponsored by the State of Wisconsin and Milwaukee County, was intended to generate an awareness of the need for skill building and systems collaboration around services for persons with mental health and/or substance abuse issues who also have experienced or are experiencing abuse or other kinds of trauma.

The goals of the conference were two-fold. First and foremost, the conference served as a forum to advance the knowledge base of all participants with regard to understanding, assessment, and treatment for persons with mental health and/or substance abuse problems who are also trauma survivors. The second goal was to expand community capacity for meeting the needs of persons struggling with these complex issues.

The process of planning the *Crossroads Conference* was a collaborative undertaking. Planners included representatives from the Milwaukee County Mental Health Division, the Wisconsin Department of Health and Family Services Bureau of Community Mental Health, and a consortium of mental health consumers and state service and advocacy organizations on domestic violence and sexual assault.

The conference was funded partially by a Substance Abuse and Mental Health Services Administration conference grant to the Wisconsin Department of Health and Family Services Division of Supportive Living. The grant made possible the award of registration and lodging scholarships for consumers, participant surveys, the printing of conference proceedings, the production of a video tape on the importance of collaboration between mental health and other agencies, and the printing of a manual comprised of articles outlining the range of perspectives and interventions central to the service delivery systems represented at the conference.

One of the results of the *Crossroads Conference* was the formation of the Wisconsin Trauma Workgroup. This group includes representatives from the Wisconsin Coalition Against Domestic Violence, the Wisconsin Coalition Against Sexual Assault, state-level administrators for mental health, substance abuse, and public health, and consumers. The group's goal is to enhance the capacity of the mental health, substance abuse, domestic violence, and sexual assault service systems to:

- respond effectively to survivors of abuse and trauma who are struggling with mental health and substance abuse issues;
- respond appropriately to perpetrators of violence who may seek intervention in these systems; ensure that those responses are culturally sensitive; and
- foster and sustain collaboration and understanding between service systems and consumers.

Additionally, stakeholders continued to “meet at the crossroads” in two local cross-trainings, one in Madison in June, 2000 and one in March, 2001 in a rural area of northern Wisconsin.

Collaborative Local *and* Regional Networking Initiatives

The DCPD/DVMHPI identified a small number of innovative, collaborative endeavors that are best described as local or regional networking models. In many ways, these models are similar to the statewide initiatives described above, but are locally focused. All five models feature a training component.

***Domestic Violence and Mental Health Policy Initiative (DVMHPI)
Chicago, Illinois***

DVMHPI

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The Domestic Violence and Mental Health Policy Initiative (DVMHPI) is collaborative effort to develop integrated models for responding to the mental health needs of domestic violence survivors and their children. The Initiative addresses the barriers and concerns mental health providers and domestic violence advocates face in attempting to meet those mental health needs.

During its first two years, the Initiative provided an opportunity for mental health agencies and domestic violence programs in the Chicago area to:

- establish common goals and principles for collaborative intervention;
- assess current needs and resources;
- address institutional and system barriers that impede both practice and access to care; and
- establish ongoing cross-agency partnerships.

The Initiative is currently working with partner agencies and consultants to develop trauma-informed service delivery models that address both advocacy and mental health concerns.

A core function of DVMHPI is to coordinate and provide training and technical assistance to a network of local domestic violence programs and mental health agencies. The project currently convenes nine interdisciplinary workgroups: four regional workgroups, four critical issue workgroups, and a policy advisory group. Composition of the groups has expanded to include substance abuse providers and child welfare specialists. The regional workgroups meet bimonthly to discuss service-delivery and training needs and to develop plans for improving and/or initiating the following processes: screening and assessment; cross-referral and cross-training; and interagency consultation. Critical issue groups are adapting or developing models for:

- working with women experiencing the traumatic sequelae of both past and current abuse within the context of ongoing domestic violence;
- working with women who have been diagnosed with serious mental illness and/or substance abuse who are being abused by a partner or someone in their support network;
- providing culturally sensitive interventions that address women's mental health needs as well as their concerns about community and spirituality; and
- addressing the developmental and mental health needs of children who witness violence.

The policy advisory group guides the ongoing work of the project and is comprised of program representatives and state, county, and city policymakers from the domestic violence, public health, mental health, and substance abuse communities including the Chicago Department of Public Health, Mayor's Office on Domestic Violence, State Office of Mental Health, State Office of Alcohol and Substance Abuse, and State Bureau of Domestic Violence Prevention and Intervention. DVMHPI is also working with its collaborative partners to integrate domestic violence/trauma-informed services into Chicago's public mental health system and to expand the scope of services provided. In addition, a legal committee is producing guidelines for mental health and domestic violence agencies on issues of documentation, confidentiality and information sharing, particularly in relation to custody and credibility of battered women.

In conjunction with its Federal companion project, Developing Collaborative Partnerships Project (DCPP), DVMHPI is working on developing a cross-training curriculum. The curriculum will integrate empowerment-based trauma theory and culturally sensitive intervention models with social justice and advocacy perspectives to address the range of issues relevant to women experiencing current partner abuse. Ongoing conversations with survivors, advocates, clinicians, and policy makers, whose work and experience bridge many of the critical issues described above, continue to be essential to this process. DCPP is also producing a literature review on domestic violence and mental health that will address both the impact of domestic violence on women's mental health and interventions designed to address those needs.

At the end of its second year, DVMHPI hosted a cross-training conference for service providers and administrators from over 70 domestic violence, mental health, social service, and substance abuse agencies. Third year plans for DVMHPI include completing an initial evaluation of the project, developing a website, and establishing a Training and Technical Assistance Resource Center. The Resource Center will maintain an up-to-date library of relevant research and writing on domestic violence, trauma, and mental health, disseminate materials and policy recommendations produced by the workgroups, project staff and consultants, and collect and provide links to information on other projects and initiatives that address issues pertinent to this work.

In addition to its ongoing evaluation, DVMHPI is conducting two research projects: 1) a qualitative study of how women from different cultural backgrounds define their mental health needs in relation to abuse and violence, and how they experience the health, mental health, and community-based supports they draw upon to address these needs, and 2) a survey of 1,000 Chicago area mental health providers to assess general attitudes, training, and practices in relation to domestic violence. Additionally, DVMHPI will provide intensive trauma training and ongoing technical assistance to staff from 18 partner agencies to support the project's long-range goals. Those goals are to develop, implement, and evaluate model integrated programs and delivery systems to better address the trauma and mental health needs of domestic violence survivors and their children in the Chicago Area, and to develop practice guidelines and policy recommendations that can be used in conjunction with other efforts across the country.

Luzerne County Domestic Violence Task Force (DVTF)
Wilkes-Barre, Pennsylvania

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An initiative is underway in Luzerne County, Pennsylvania to improve mental health and other human service providers' response to victims of domestic violence, sexual assault, child abuse, and elder abuse. Since its inception in 1991, the Luzerne County Domestic Violence Task Force has developed coordinated and consistent responses to victims by law enforcement as well as court and medical systems. It is nationally known as a model community response to family violence and sexual assault.

In 1996, the Task Force formed a Social Service Coordination Subcommittee, comprised of professionals from the behavioral health, addictions, and victim services communities. Following an initial training conference for mental health, substance abuse, and other human service providers, the subcommittee embarked on a project to develop routine screening protocols for the identification of family violence victims who seek services in the mental health, drug and alcohol, and other counseling service systems.

Initially, the subcommittee believed that minor modifications could be made to protocols that had already been developed for, and implemented in, Luzerne County health care settings. However, the group quickly determined that medical protocols are not a good fit for mental health and other human service settings, primarily because they do not take into account the long-term interactions that generally characterize client-helper relationships in those settings. Medical protocols also did not prescribe interventions other than support, information provision, and referral; most human service providers, however, are in a position to provide, and expect to provide, "treatment" focused intervention.

The protocol that was eventually developed helps clinicians to: 1) screen for domestic violence and other kinds of trauma, and 2) promote safety. The treatment piece was intentionally left out of the protocol, based on the subcommittee's wish not to limit the broad group of providers (and clients) with any single approach.

The treatment conundrum was addressed in the Task Force's training efforts. Multiple protocol-based trainings were offered in 2000 and provided continuing education credits for psychologists, social workers, and substance abuse counselors. (Three hundred and thirty-eight human service professionals attended one of the eight training sessions.) Following the protocol trainings, Sandra Bloom, M.D. has been engaged by the Task Force to provide the treatment component of the training vis-à-vis instruction in trauma theory and guidelines for creating trauma-specific healing environments using the Sanctuary® model described in Bloom, S.L. (2000).²

² Bloom, S.L., (2000). Creating Sanctuary: Healing from Systematic Abuses of Power. *Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations* 21 (2), 67-91.

Since the trainings, several initiatives have been embarked on. Community-based mental health centers (child and adult) have engaged Dr. Bloom to provide ongoing training and case consultation to their staff. Domestic violence advocates are routinely invited to participate. In addition, the Task Force has established a multi-system Trauma Subcommittee to look at primary, secondary, and tertiary trauma prevention/intervention strategies.

In addition, the Domestic Violence Service Center, one of the co-sponsors of the Task Force, has recently established a mental health advocacy project with Northeast Counseling Services (NCS), a comprehensive behavioral health service provider. The goals of this provider are to establish policies and procedures that promote screening for domestic violence and to provide training to clinicians as well as on-site domestic violence services in three NCS centers. The Pennsylvania Coalition Against Domestic Violence is funding this project.

Finally, in order to assist professionals in the community with “tough cases” involving interpersonal violence, the Task Force has established a Case Support and Policy Advisory Team (CSPAT). CSPAT is a specialized, cross-sector, multidisciplinary team made up of professionals from protective services, health care and mental health, victim advocates, law enforcement, substance abuse and other counseling services, and housing. CSPAT’s goals include:

- improving communication among systems;
- increasing awareness about factors in interpersonal violence;
- identifying additional resources for clients and professionals; and
- generating new options and innovative approaches.

Collaborative Direct Service Programs

This report describes a range of collaborative programs. Some began as mental health or substance abuse programs that broadened to address trauma in general and/or domestic violence. Others started as domestic violence programs and subsequently added a trauma/mental health component. Most address the needs of children who experience domestic violence and the parenting concerns of their mothers; some provide interventions for perpetrators as well. Lastly, one model incorporates an economic development program that helps women to achieve the economic self-sufficiency necessary to rebuild their lives.

***Elizabeth Stone House
Jamaica Plain, Massachusetts***

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Located near Boston, Massachusetts, the Elizabeth Stone House (Stone House) started as a feminist alternative mental health program, founded in 1974 by a group of women who were former patients in the mental health system. Stone House currently offers three residential programs, including a shelter where battered women are encouraged to reclaim control over all decisions that impact their lives and the lives of their children. Early in its development, the Stone House recognized the link between the traumatic impact of victimization and the mental health problems of women who sought refuge there.

The Battered Women's Program (BWP) is an eight-week shelter program for women and children. Services provided in the BWP are similar to those offered in most other emergency domestic violence shelters: individual counseling and support groups, safety planning, programs for children, information about legal remedies, court advocacy (such as assistance with protective orders advocacy with child protective services), and immigrant rights information.

The Therapeutic Community (TC), Stone House's original residential program, is a five-month alternative to the traditional mental health system. It is the only residential mental health program in the country that allows and encourages women to bring their children with them. While in the TC, residents receive therapeutic and supportive mental health services from clinically trained staff in the context of an empowering environment. To help foster self-esteem and self-determination, residents work with an advocate to prioritize goals. Advocates also provide information about employment, housing, financial planning, and ongoing therapeutic services for mental health and substance abuse issues.

The TC is unique in that women can exercise the option of maintaining custody of their children while participating in a residential treatment program. While at Stone House, mothers work with staff members to assess their children's needs and develop their own capacity to respond. Services are also provided to children, including advocacy and supportive counseling. Additionally, the Stone House facilitates a Reunification Group for mothers and children who have been separated through institutionalization or foster care.

Stone House also operates an 18-month Transitional Living Program for women and children completing a treatment program or leaving a battered women's shelter, providing an extended opportunity for women to achieve personal goals as they move from shelter to permanent housing.

The Battered Women's Program and the Therapeutic Community are located in the same building and share the same facilities. Many women in the TC have a history of victimization; likewise, many women in the BWP are struggling with the mental health sequelae of abuse. Although the intake procedures and length of stay differ between programs, residents in one program can (and frequently do) participate fully in the other. For example, a woman in the BWP may participate in a psychotherapy group; conversely, a woman in the TC may attend support groups for battered women. Both programs operate on the assumption that women are able to heal only when they are empowered to make their own choices and are in an environment where their choices are supported.

All services offered by Stone House are available to residents of the Transitional Living program as well.

In addition to its residential services, Stone House offers an array of walk-in and community-based programs that promote autonomy and healing, including support groups on topics such as violence, addictions support, mental health, and parenting. Most relevant to this report is the Nurturing Program, a fifteen-week curriculum that addresses a range of parenting and child development issues. Facilitators lead parents' and children's groups through activities and discussions intended to improve communication within the family; participants are encouraged to examine how environmental stresses, community, and family of origin influence parenting styles and to learn to communicate without violence.

Stone House's Outreach and Education Program offers training in women's mental health, domestic violence, working with trauma survivors, group facilitation skills, and empowering women. They offer this training to mental health clinicians, social workers, counselors, advocates, and service providers in hospitals, schools, community agencies, treatment centers, and homeless shelters. In 1991, Stone House developed The Elizabeth Stone House Handbook: Sheltering People in Emotional Distress, a "how to" handbook for developing community-based residential mental health alternatives.

Through its Community Education for Economic Development (CEED) program, Stone House provides an innovative model for assisting women to achieve economic self-sufficiency within an ongoing network of support. The Personal Economic Planning curriculum teaches economic literacy and goal planning; the Economic Opportunity Network links women to training, education, and employment opportunities; and the Women's Business Opportunity Program (WBOP) is a comprehensive micro-enterprise program that helps women' to establish their own businesses. The Women Mean Business Network provides access to ongoing technical assistance and support. While not focused specifically on mental health, the CEED and WBOP programs form are of a comprehensive network of support for women s they heal and rebuild their lives.

***Shared Domestic Violence and Mental Health Case Manager Model
Durham, North Carolina***

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Several years ago, a domestic violence program in North Carolina took the initiative to collaborate with their local public mental health agency (Cleveland Center) to write a grant that would support a new shared case manager position. Although the position was eliminated after several years due to loss of funding, the model is noteworthy in that it illustrates a number of the themes that have emerged in gathering information for this report.

The case manager provided flexible, client-centered interventions to women in both service settings. She worked with women in the public mental health clinics around issues related to past and current experiences of domestic violence, providing traditional case management within a framework of advocacy and empowerment. Likewise, she worked with women in the domestic violence shelter who were experiencing the mental health sequelae of abuse, providing the additional support and resources necessary for women with substance abuse and mental health issues.

Although the program is now defunct, Mary Beth Loucks-Sorrell, the case manager of the domestic violence agency that originally developed the model and currently the Technical Assistance Coordinator at the North Carolina Coalition Against Domestic Violence, considered it a success and offered a number of insights. First, the model allowed for a great deal of flexibility. Women were able to access important services (e.g., psychiatric assessment and supportive case management for women in shelter; advocacy and safety planning for women in mental health clinics) without having to enter another service delivery system. Second, although the model was not evaluated it was thought to be highly effective. Many women referred to the case manager from the mental health clinics had been diagnosed with personality disorders (primarily borderline personality disorder). However, in the context of a supportive, empowering relationship with the case manager, most of the women's mental health symptoms were found to reflect traumatic sequelae of abuse rather than true personality disorders. The grassroots impetus for establishing this position was also important to its success. While the model represented a clear opportunity for improved collaboration and communication between systems, the experience in this case was that the mental health system was not designed for and did not encourage this type of partnership. Specifically, mental health counselors carried such large caseloads they did not have support from their organization to staff cases and develop effective interventions.

***Horizons Shelter, Jewish Board of Family and Children's Services
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Horizons Shelter in New York City integrates trauma focused mental health care into a shelter for battered women and their children. Horizons Shelter is one of over 150 programs administered by the Jewish Board of Family and Children's Services, a large social service and mental health agency in New York. A key feature of the shelter is its focus on empowerment and leadership issues.

Horizons Shelter provides crisis intervention, advocacy, and short-term psychological treatment for women and children. Cognizant of the fact that families are seeking safety and transition to affordable housing, not therapy, the shelter balances traditional domestic violence services with progressive, trauma-focused mental health services.

Program staff have diverse levels of professional training. The team includes advocates, social workers, a psychiatrist who specialize in traumatic stress disorders, and milieu workers. It is the shelter's philosophy that empowered workers who understand the importance of their role relative to the mission of the program are best able to empower clients. This philosophical stance is based on the Sanctuary® model, developed by Sandra Bloom, M.D. and colleagues, which is currently being adapted for use in these domestic violence shelters. Originally developed for an adult psychiatric inpatient setting, the Sanctuary model combines trauma theory and treatment with principles for establishing therapeutic communities and practicing nonviolence to create a safe, empowering environment in which trauma survivors can heal and grow. A key tenet of this model is that a healthy therapeutic environment – one that fosters mutual responsibility, respect, dignity, and communication - is critical to the outcome of the interventions.

A variety of services are available at Horizons. Those that clients must utilize include: housing and legal advocacy, mental health assessment, group counseling, and individual counseling for women; school advocacy and trauma impact assessment for children; and psychosocial assessment for families. Other services can be added if clients choose, such as: cognitive/behavioral therapies, skills rehearsal, and psychotropic medication for women, art therapy and psychiatric assessments for children, and family therapy. (In the context of this program, "families" refers to mothers and children together.) Finally, all clients participate with appropriate staff in community meetings to share knowledge and foster a physically and emotionally safe environment for residents and staff alike. A description of this approach appears in Panzer, P.G., Philip, M.B., & Hayward, R.A. (2000). Trends in domestic violence service and leadership: implications for an integrated shelter model. *Administration and Policy in Mental Health*, May, 27 (5), 339-352.

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Asha Family Services, Inc. (Asha), is a spiritually based, private, non-profit, people of color-governed organization committed to providing comprehensive culturally specific family violence, mental health, and substance abuse services for victims and perpetrators of domestic violence. Asha (a Swahili and Indian word meaning "Life" and "Hope") is the first and only domestic abuse program in the state of Wisconsin designed explicitly for African Americans. Since its inception in 1989, Asha (formerly known as the Asha Women of Color Project) has provided direct services to over 3,000 victims of domestic abuse annually and has engaged in collaborative efforts to facilitate safety, healing and growth in families. Ninety percent of Asha's client population is comprised of single female-headed households who live at or below federal poverty guidelines for "Extremely Low" or "Very Low" income levels.

Over the years, Asha's programming has become more complex in its approach to domestic violence. Asha now proceeds on the premise that in order to adequately address family violence and promote healthy communities and strong families, it is critical to treat the abuser as well. Asha believes in the preservation and strengthening of the African American family and that a healthy and vibrant community is a reflection of strong, healthy, vibrant, and resourceful families residing in it. This has led to a commitment to provide holistic and culturally responsive services to end violence against African American women and children specifically, and families of other communities of color and all families in general, and to provide a continuum of care, not only for the transformation, restoration and empowerment of injured families, but also for a range of clientele including persons at higher risk for HIV infection, mental health and substance abuse clients, and those incarcerated and transitioning back into the community. Asha holds a State license to operate a full-scale outpatient mental health and substance abuse treatment clinic that includes HIV/AIDS education and counseling. Asha also provides a range of domestic violence related services for women, children, youths, and men. Services for women and children are described below.

Clinical Services

Family and Individual Case management: Qualified family violence prevention advocates provide case management and advocacy services for families who need assistance in accessing community services and supports. Case managers assist families in developing an individualized case plan for all family members and monitor the client's progress in using community and agency services. Services often are performed in the client's home.

Substance Abuse and Mental Health Treatment Services: Since 1995, Asha Family Services has operated a community-based, state-licensed outpatient mental health and substance abuse treatment clinic that is culturally responsive. It specializes in family counseling regarding childhood and adult victimization, anger, grief and stress, and the intersections among family abuse, mental health problems, and substance abuse problems. Experienced, licensed therapists and substance abuse counselors staff the clinic.

Services for Women

Sister Circles: Designed originally by and for African American women, Sister Circles provide a safe place to exchange ideas and experiences by helping to eliminate fears and to foster feelings of friendship, sisterhood and trust and to facilitate healing, self-development and love. Participants receive domestic violence and sexual assault prevention information, safety planning, intimate partner and sex-related issues education as well as HIV/AIDS and other STD education, information, and referrals. Systems advocacy and case management services are tailored to the individual and/or her family. Services are provided via peer support and credentialed staff counseling. Sister Circles include groups for women who are post-incarceration or currently incarcerated via Asha's Corrections Care Continuum. Groups meet weekly for two hours each. Transportation is available and services are culturally specific.

Corrections Care Continuum: CCC provides comprehensive services to male and female offenders incarcerated in facilities throughout the state. Within women's prisons, Asha conducts ongoing victim support groups and provide family-inclusive transition case management for women re-entering the community. The program includes a project called "Exodus" for women involved in sex for money, illegal drugs, and retail theft.

Brothers Against Domestic Violence (BADV) is a growing nonprofit organization focused on women's safety. BADV offers bodyguard escort services and emotional support to help women feel safe while getting a restraining order, appearing in court, or going on any potentially dangerous outing. Additional services include training in fitness, self-defense, nutrition, and safety.

Pre/Post Partum Depression Screening. Pre- and post-partum women are assessed for depression and, if necessary, linked to community-based intervention services for depression that are both culture- and age-appropriate. These services are provided to women incarcerated in Milwaukee County Jails.

HIV/AIDS Education and Outreach. Asha provides community outreach, education, and referrals for persons at risk for HIV/AIDS.

Services for Children and Youth

Our Children's Advocacy Project (OCAP) provides services on-site and at area schools for children who witness or experience domestic abuse. OCAP's goals are to:

- break the isolation of children who experience violence in the home
- teach children and youth how to protect themselves by developing safety and support systems
- promote emotional and physical health
- strengthen self-esteem

OCAP Parenting Sessions. OCAP conducts regularly scheduled parenting classes for parents and child caregivers.

Young Sisters Support Group. Designed for adolescent girls ages 13-17, this service uses a didactic/experiential approach to:

- address girls' life management needs
- help them develop emotional competencies
- find alternatives to aggressive thinking, and
- develop anger management skills

Computer Lab. Training classes on current computer programs are offered for adults and children to assist with school and job skills and to familiarize participants with accessing information through the Internet.

Community Education/Training. Asha conducts presentations for schools, churches, correctional facilities, social service agencies, businesses, and other organizations on strategies for working with African American populations to address interpersonal violence, HIV/AIDS, and other social ills.

Male Perpetrators

Asha also provides a number of programs for male perpetrators of domestic violence. It is critical to Asha's mission to offer services that promote healing and change both within individual families and for the African American community. Asha Family Services is one of the only programs to integrate services for mental health, substance abuse, and domestic violence in a way that addresses the complex needs of domestic violence survivors and their families within a spiritual, cultural and community context.

**SAMHSA: Women, Co-Occurring Disorders,
and Violence Study**

The U.S. Department of Human Services, SAMHSA Women, Co-Occurring Disorders, and Violence Study is a two-phase multi-site study to develop, implement and evaluate innovative service integration models for meeting the complex needs of women trauma survivors with mental health and substance abuse disorders. The two-year initial phase of the project allowed thirteen sites plus a coordinating center to assess needs, develop models for delivering integrated services, and establish the collaborations necessary for their implementation and evaluation. Phase II of the study provides support for nine sites to implement and evaluate these model programs. While the majority of projects involve expansion of services to integrate responses to trauma within existing programs, others have focused on system-level integration within larger communities. All are charged with developing models that in some way improve the integration of services within the complex array of systems with which women must interact.

Although this study is not targeted specifically for domestic violence survivors, most sites do serve significant numbers of battered women within their programs. A number of projects initially had difficulty engaging domestic violence programs as full partners. However, most are actively addressing the integration of domestic violence services into their programs—some through collaboration with domestic violence agencies, others by developing their own on-site domestic violence services.

The accomplishments of the first two years have been quite impressive and offer important models for comprehensive service delivery that will be useful to domestic violence programs as well as to mental health and substance abuse agencies and providers. Projects that have specific domestic violence components will be described in the following pages. A critical feature of this study is its strong commitment to consumer/survivor involvement at all levels of planning, evaluation and implementation. This has led to models that, in general, are relational/empowerment/strength-based and sensitive to cultural issues.

***PROTOTYPES, A Center for Innovation in Health, Mental Health, and Social Services
Culver City, CA***

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Perhaps the most comprehensive in scope, PROTOTYPES, a Center for Innovation in Health, Mental Health and Social Services, is a nonprofit organization providing services to over 10,000 women and children each year. Its clients include those who are homeless, those addicted to drugs and alcohol, those living with and at-risk for contracting HIV/AIDS, those who are diagnosed with mental illness, and those who are victims of violence. PROTOTYPES has 24 community service locations throughout Southern California, which provide multicultural and multilingual prevention, intervention/treatment, and training services. Two Thrift Stores provide training and employment for clients in addition to generating funds for the agency.

PROTOTYPES programs include a comprehensive substance abuse treatment facility for women and their children that offers residential, outpatient, and day treatment services with specialized components for women living with HIV/AIDS and women who are survivors of violence. PROTOTYPES also houses Women's Link and Women's Care, two collaborative consortiums that provide comprehensive health, mental health, and social services to women living with HIV/AIDS and their families. Other services include a street outreach program, drop-in centers, or child mental health program, and an HIV/AIDS Media Campaign for Women of Color. Additional collaborative components offer outreach services to adolescents, training, technical assistance to other agencies and providers, and research. A significant percentage of staff positions are held by consumer/survivors.

The PROTOTYPES Systems Change Center is working to develop integrated service delivery models for women with multiple vulnerabilities. The Women's Center in Pomona is planning to implement a "one-stop shopping model" that will provide services of physicians and psychiatrists as well as mental health providers and substance abuse counselors. An intensive case management strategy is being utilized to integrate a wider range of services to meet the needs of women and children. Similar to several other programs in this study, PROTOTYPES provides its own domestic violence services on site. The Systems Change Center has also been working to integrate mental health, substance abuse, and trauma services within Los Angeles County through its Local Experts Group.

Prototypes Domestic Violence Programs

PROTOTYPES Domestic Violence Programs utilize a holistic approach in working with women who have multiple vulnerabilities. The programs use street outreach and community resource and drop-in centers as ways to engage women who have mental and/or substance abuse disorders and women who are survivors of domestic violence. While some of Prototypes' outreach activities are similar to those of other domestic violence programs across the country, these are reported in more detail because they are delivered in the context of comprehensive mental health, substance abuse and trauma services. Their programs are as follows:

S.T.A.R. House (Succeeding Together Achieving Recovery). S.T.A.R. House is a transitional housing support program that houses approximately 10 women and their children with a total capacity of 20 individuals. It provides domestic violence services to women with multiple vulnerabilities (homelessness,

substance abuse, HIV/AIDS, mental disorders, and/or trauma). Very few domestic violence programs in Los Angeles County serve this population, and the women come primarily from under-served areas.

Services include individual case management, domestic violence groups, substance abuse treatment, and parent support groups. The Program offers a comprehensive, and culturally competent, state-of-the-art treatment model specifically designed to meet the needs of dually-diagnosed battered women with multiple vulnerabilities.

Case management prepares women to manage their circumstances, reduce their sense of hopelessness, and move toward recognizing that they are in charge of their lives through an instructional format. Women are assisted in designing individualized treatment plans to meet their multiple needs. Health and wellness services such as nutrition, exercise, and referrals and advocacy for health insurance and medical care are also part of the program. Vocational services are provided to help women achieve their long-term goals of employment and self-sufficiency. In addition, the case manager further assists women in finding permanent housing to ease their transition back into the community.

The Children's Program provides services for children in the domestic violence programs, including individual therapy, violence awareness groups, advocacy with the schools, and recreational activities.

CalWORKS Domestic Violence supportive Services Program. PROTOTYPES is participating in the CalWORKs Domestic Violence Supportive Services Program with the County of Los Angeles Office of Community and Senior Services. The County has acknowledged domestic violence as a barrier to employment for many welfare (TANF) recipients and has implemented this project to address such issues. The goal of this program is to foster the empowerment, employment, and long-term self-sufficiency of women residing in under-served communities. Since March 1999, PROTOTYPES has provided culturally and linguistically sensitive, non-residential domestic violence services for CalWORKs participants and often refers other clients to CalWORKs/GAIN.

Family Violence Prevention Initiative Program. The PROTOTYPES Domestic Violence Programs are working to improve access to much-needed services for victims and families of domestic violence in the Hollywood and mid-Wilshire communities of Los Angeles by way of the D.A.R.T. (Domestic Abuse Response Team) Program and a number of other outreach activities. The primary goals of this program are to:

- increase the integration of shelter and law enforcement services to domestic violence victims and their families;
- increase awareness of the scope of violence in the family;
- increase access to shelter and legal services for hard-to-reach populations of undocumented refugee and immigrant domestic violence victims and their families; and
- increase awareness of the role of substance abuse and mental illness as co-factors in family violence.

PROTOTYPES utilizes several key strategies to create this multidisciplinary approach, including trainings for domestic violence shelters, law enforcement agencies, legal service providers, emergency shelters and crisis intervention workers. Strategies also include the creation of a Coordinated Family Violence Consortium that meets quarterly to develop tools and resources to accompany trainings, and the development of a Coordinated Family Violence Response Team that analyzes and responds to the specific needs of crisis victims and their families.

PROTOTYPES and its collaborative partners offer a unique composition of services. These include the capacity to address substance abuse and mental illness, as well as language and cultural barriers, all of which have historically prevented many victims from accessing critically needed services.

PROTOTYPES Domestic Violence Resource Centers. PROTOTYPES also operates Domestic Violence Resource Centers in two communities. Services include community outreach, case management, service assessment, service planning, monitoring of participants' progress, job readiness and placement assistance, permanent housing assistance, transportation, childcare, food, clothing, and service follow-up. Structured one-on-one and group counseling with participants in crisis and non-crisis situations are designed to address healing, empowerment, and client motivation towards a life free from abuse.

PROTOTYPES Legal Clinic. Inner city survivors of domestic violence, sexual assault, and stalking who live in under-served communities often have multiple vulnerabilities, including immigration, mental health, substance abuse, and HIV/AIDS issues. Such survivors may be reluctant to access legal resources for various reasons, including fears for safety, lack of availability in their communities, negative experiences with and/or fear of the justice system, lack of knowledge and information about legal rights and services, and fear of stigmatization. These victims often require a number of services, including outreach, medical care, and counseling, but they also often require legal assistance as a prerequisite to obtaining such services. PROTOTYPES Legal Clinic provides safe on-site legal services in a linguistically appropriate and culturally sensitive manner. The clinic is staffed by two legal advocates and two attorneys from the communities being served.

New Directions for Families
Thornton, Colorado

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The site for the New Directions for Families program is the Arapahoe House, a large substance abuse treatment agency that also provides treatment for people with co-occurring mental and substance abuse illnesses. New Directions is a self-contained residential treatment program for women and their children. While it has access to resources available through the parent agency, it has also established its own connections with community service providers. Intensive substance abuse, trauma, and mental health treatment, as well as parenting and job skills training, are the initial focus of interventions. Providing support and advocacy to assist women with their transition and integration into the community is a major component of this program's second phase.

New Directions conducts outreach and screening to identify trauma survivors and engage them in integrated trauma/substance abuse treatment. It offers safety planning and specialized trauma-informed services to assist women with community reintegration. It also provides a Children's Services specialist and a Family Therapist for children who witness violence, women's groups to address issues of trauma and domestic violence, and referrals for legal assistance. This program is using the Trauma and Recovery Empowerment Model (Maxine Harris, 1998) with the women it serves.

To foster collaboration among fields, New Directions convened a group that included shelter directors; executive directors of domestic violence programs; and mental health, substance abuse, and child welfare workers. The group began by discussing both barriers and principles to use in refining the programs they

run. The emphasis on articulating shared values as well as attempting to understand differences has been important to the ongoing collaboration. Staff are cross-trained in domestic violence, trauma, substance abuse, and mental health.

Ongoing collaboration is achieved through a Community Advisory Board that provides oversight to ensure that the program remains sensitive to violence issues and that women are getting the services they need. The program incorporates a consumer perspective by hiring consumers as staff and convening monthly meetings of a Consumer Council to provide recommendations for improvement in the program. The program also incorporates a child-witness-to-violence component based on the 9-week *Groupwork with Children of Battered Women* (1995) model developed by Einat Peled and Diane Davis that has been adapted to include issues related to living with a substance abusing parent.

One of the greatest barriers faced in working with domestic violence programs is the concern that if battered women become identified as substance abusers rather than “victims,” public opinion will turn against them, blaming them for their situations. Stigma surrounding substance abuse and how that is used against women remains a critical issue for both communities.

A second set of issues relates to the involvement of child welfare agencies in the lives of substance abusing women. Program Director Nancy VanDeMark commented on the importance of understanding the motives of the systems with which agency staff interact and finding people within those systems who want to help women move into better circumstances. There was a great deal of respect for concerns of domestic violence programs around issues of safety, stigma, and child custody.

DC Trauma Collaboration Study
Washington, D.C.

Community Connections

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Community Connections is a residential treatment program for women with serious mental illness, substance abuse, and histories of trauma. It has a well developed, manualized trauma treatment program called Trauma Recovery and Empowerment Model (TREM), that is largely informed by the experiences of the women it is designed to serve (see Curricula and Training Materials). Community Connections brings together an array of service providers in the DC area to improve service integration across agencies and sectors. Domestic violence has not been a major focus of these interventions as the majority of women in the Community Connections program are living in safe, subsidized housing at the time of their participation. However, domestic violence groups are being offered at this site.

Massachusetts Programs

Three different programs in Massachusetts have integrated domestic violence services into their models to varying degrees. In this state, considerable work has been done on the integration of domestic violence and *substance abuse services*. For example, the Department of Social Services now funds two domestic violence shelters (and potentially a third) specifically for substance abusing women and their children. In addition, there are domestic violence advocates in all child welfare offices, where there is growing awareness of the intersection between domestic violence, substance abuse, and mental health.

Franklin County Women's Research Project

Greenfield, MA

(A project of the Western Massachusetts Training Consortium)

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The Franklin County Women's Research Project (FCWRP) is a CSR (Consumer, Survivor, Recovering person) led initiative that is working with a range of community agencies in rural Western Massachusetts to develop more integrated intervention models for survivors of gender-based trauma. Partners of the Western Massachusetts Training Consortium include the New England Learning Center for Women in Transition (NELCWIT), Franklin Medical Center, and Rutgers University. The program is co-located at three drop-in centers that provide a variety of supports and services to women who have experienced physical or sexual abuse, including rape, incest, or battering. All three centers offer peer-run services, counseling, trauma groups, AA meetings, creative workshops, and childcare. Peer advocates are trained to provide support and help women connect with area resources. The Survivors' Project drop-in center, a program of NELCWIT, is located in Greenfield. NELCWIT has an 18-bed shelter available for women who are homeless and/or have experienced abuse and violence in their lives. The Turners Falls Women's Resource Center operates under contract with Montague Catholic Social Ministries in Turners Falls, and the Daybreak Women's Resource Center in Orange operates under contract with ServiceNet/Orange Family Inn, a homeless shelter for families.

Women who visit the drop-in centers have the option to participate in 12-week ATRIUM groups. ATRIUM (Addiction and Trauma Recovery Integration Model), developed by Dusty Miller, Ph.D., is a manualized trauma recovery program designed to help women survivors of early childhood physical and sexual abuse and/or domestic violence end their struggles with addiction.

Mental health and substance abuse services are provided at Franklin Medical Center. Under contract with The Consortium/FCWRP, Franklin Medical Center supports a trauma liaison position to foster connection and collaboration between area agencies and to coordinate trauma-informed services at the hospital and in the community. The trauma liaison also provides cross-training of advocates and substance abuse and mental health providers.

This model, like many others in the SAMHSA study, utilizes a feminist empowerment-based trauma intervention model with a strong peer support component. This is the only site, however, in which service integration takes place at a domestic violence agency. Interestingly this is one of the very few domestic violence agencies that targets services and provides shelter to survivors of sexual assault and childhood

sexual abuse as well as domestic violence, one that already provides an unusual degree of integration. Additional strengths are the peer advocacy and empowerment values shared by the partners. Tensions arise out of the differing primary foci of each program: providing trauma services versus working for social justice, and intervention for individual women versus advocating for social change. The genuine respect between partners despite their differing priorities has been critical to this collaboration.

***Women Embracing Life and Living (W.E.L.L.) Project
Cambridge, Massachusetts***

Institute for Health and Recovery
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Women Embracing Life and Living (W.E.L.L.) Project at the Institute for Health and Recovery is working to develop services that address substance abuse, mental illness, and trauma in an integrated fashion. The overall goal is to have integrated services become the norm throughout the state of Massachusetts. To accomplish this, the project works at multiple levels.

In order to have a direct impact on service delivery, W.E.L.L. works closely with three large local agencies that provide mental health and substance abuse services: Their sites are CAB Health and Recovery, serving Northeast Massachusetts, and the Gosnold and Stanley Street Treatment and Resources; Stanley Street serving Fall River, and Gosnold, serving Cape Cod, Nantucket, and Martha's Vineyard. During the two-year planning phase of the project, W.E.L.L. worked with a panel of clinical experts to develop a cross-training curriculum that addresses substance abuse, mental illness, physical and sexual abuse, and domestic violence. The curriculum was delivered to all levels of staff at participating sites. In addition, sites are provided with two hours of supervision per month to address difficulties in providing integrated treatment.

W.E.L.L. staff piloted a number of group treatment curricula to address trauma, and eventually chose *Seeking Safety, A Treatment Manual for PTSD and Substance Abuse* written by Lisa Najavits, Ph.D., as a core intervention. The Institute for Health and Recovery adapted its parenting curriculum, the *Nurturing Program for Families in Substance Abuse Treatment and Recovery*, to include information about mental illness and violence, and thereby created a new curriculum, *Nurturing Families Affected by Substance Abuse, Mental Illness, and Trauma*. In addition, the W.E.L.L. Project's Consumer Coordinator partnered with Vinfen, Inc., a large mental health agency that provides self-help groups for dually diagnosed individuals statewide, to develop a mutual help curriculum for women in recovery from substance abuse, mental illness, and trauma. In the second phase of the SAMHSA study, the outcomes of women who have access to these integrated interventions and an Integrated Care Facilitator who provides resource coordination and advocacy services will be compared with women receiving services as usual at Spectrum Health Systems, Inc., another large substance abuse and mental health provider.

Since women with multiples issues often receive services from multiple agencies, the W.E.L.L. Project addresses integration at the community level as well. While the three local sites are now trauma-informed, linkages need to be enhanced between these sites and domestic violence and sexual assault providers, mental health providers, homeless service providers, and others in order for integrated treatment to be provided in all service systems. In order to accomplish this, the WELL Project convened Local

Leadership Councils in the three communities surrounding the local sites, inviting service providers and consumers from each of these service systems to discuss and develop integrated models of care. The Local Leadership Councils participated in a values clarification process so that providers would understand the histories and points of view of the different service systems and how these differences could interfere with collaboration. The Councils received the same cross-training that was provided to the local sites. They then began a series of dialogues which resulted in the development of an “Ideal Integrated Continuum of Care,” and identified what was needed in terms of changes in policy, program, and training of staff for care to become truly integrated.

Each Council then developed its own project to move toward a more integrated service system. In Fall River, members chose to develop a universal screening instrument for domestic violence and train all providers in the region on conducting such screening. On the Cape, the Council chose to develop a means by which providers could cross-train each other’s staff members. And in the Northeast, members chose to develop a brochure about identifying and conducting safety planning with women in domestic violence situations.

The Local Leadership Councils passed their recommendations for policy changes and pilot projects to the WELL Project’s State Leadership Council. This Council consists of representatives from state agencies that might have contact with women with co-occurring disorders and trauma, such as the Department of Social Services, the Department of Mental Health, the Department of Public Health and its Bureau of Substance Abuse Services, and the Division of Medical Assistance (Medicaid). It also includes representatives from consumer advocacy organizations, such as Jane Doe, Inc. (The Massachusetts Coalition of Domestic Violence and Sexual Assault Providers), the National Alliance for the Mentally Ill, the Massachusetts Organization for Addiction Recovery, and some service-provider organizations.

While there has been increasing collaboration between the domestic violence and substance abuse communities in Massachusetts over the past five years, addressing trauma-related mental health issues is a more recent focus. Growing recognition of the need to provide specific services to battered women with substance abuse problems has led the Department of Social Services to fund two shelters specifically for substance abusing battered women and their children. One of these shelters, Spiritus at CAB Health and Recovery, is a W.E.L.L. Project site. Another W.E.L.L. Project site, Stanley Street, also has its own women’s center and domestic violence program. Stanley Street and CAB also provide combined substance abuse and mental health services, including services for people diagnosed with more severe mental disorders. The State Leadership Council was formed to promote the development and proliferation of these and other integrated treatment models.

The State Leadership Council accepted the recommendations of the Local Leadership Councils and now works toward implementing them. The Council also developed a set of *Principles for the Trauma-Informed Care of Women with Co-Occurring Mental Health and Substance Disorders*, and the state agencies have all signed statements in support of those principles, indicating their agreement that the principles represent the ideal basis for delivering care to this population. This has promoted awareness of the need for trauma-informed and trauma-specific services. The Massachusetts Department of Public Health/Bureau of Substance Abuse Services has announced its intention to fund trauma and parenting groups within outpatient substance abuse treatment. In addition, the Mental Health and Substance Abuse Corporation of Massachusetts, the statewide provider organization for mental health and substance abuse services, included training providers about trauma among its priorities for 2002. The W.E.L.L. Project continues to work toward implementing these and other statewide initiatives that will further the integration of substance abuse, mental health, and trauma services.

Boston Consortium of Services for Families in Recovery
Boston, Massachusetts

Boston Public Health Commission
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The Boston Consortium of Services for Families in Recovery, in conjunction with the Boston Public Health Commission and the Boston Medical Center (BMC), has developed a trauma-informed integrated system of care for women seen in their four substance abuse treatment programs. The system includes two residential programs for women and children (including one of only two bilingual, bicultural programs for Latinas), and two outpatient programs. Partners in this collaboration include the Child and Adolescent Emergency Treatment Team in the Department of Psychiatry and the Substance Abuse Prevention and Treatment Program at BMC, Harvard Street Neighborhood Health Center, and two domestic violence programs, Casa Myrna Vasquez and the Elizabeth Stone House.

Cross-trainings were conducted during phase I to address philosophical differences and to achieve consensus on how to help women with co-occurring disorders. Trauma interventions are designed around a modified Trauma Recovery Empowerment Model (TREM) program, which is 25 weeks long instead of TREM's usual 33 weeks. The Boston group has also added HIV components to this model. This curriculum, which was initially designed to address the adult sequelae of childhood sexual abuse, focuses on how childhood sexual abuse can affect adult relationships. Many women in this program begin using drugs in the context of an abusive relationship. Other trauma informed interventions include:

Trauma-Mental Health Assessment, Treatment, and Service Coordination: The Trauma/Mental Health (T/MH) Service Coordinator, under contract with the BMC Department of Psychiatry, is responsible for conducting a diagnostic trauma/mental health assessment and for assisting women in implementing aspects of the treatment plan that involve mental health and trauma treatment or related services. The T/MH Service Coordinator works in collaboration with the substance abuse counselor through attendance at clinical meetings at the intervention sites.

Consumer Leadership Training Institute (CLTI): CLTI offers peer run, curriculum based groups that meet for three days of five-hour/day intensive training on leadership and communication skills. The groups discuss how the experience of trauma works to silence women and how to facilitate the process of regaining one's voice. This curriculum was translated into Spanish and culturally adapted for Latinas.

Family Reunification Groups: This curriculum-based group uses a psychoeducational skill-based approach for mothers who are in the process of regaining custody of their children. It was developed and is currently used at the Elizabeth Stone House with women with co-occurring disorders. The group is conducted in 12 weekly sessions (1.5 hours each). It supports women's recovery from trauma by providing women with skills that strengthen family functioning, helping them learn about the impact of abuse, and empowering them to act constructively to regain custody of their children.

Personal Economic Planning: A curriculum to teach financial skills is offered in four group sessions (two hours each) at the intervention sites. The group facilitators are from Elizabeth Stone House, which developed this curriculum for women with co-occurring disorders (see above).

This group has focused its efforts on three areas: policy and financing, service issues, and consumer leadership and networks. Strategies include revision of financial policies and development of integrated funding streams. Collaboration with domestic violence programs centers on cross-training, cross-consultation and cross-referrals as well as shared assessment and case management protocols. Biweekly Steering Committee meetings for directors and clinical directors from intervention sites as well as liaisons from collaborative partners help address clinical and systems barriers to integration. The project also hosts a Consumer Roundtable as well as a Service Integration Roundtable with counselors and service providers from substance abuse, domestic violence, and mental health. Advocacy training on domestic violence, substance abuse, and mental health is offered for recovering clients in the programs. This was one of the few sites in which domestic violence agencies played a lead role in the integration and collaboration with substance abuse and mental health programs. One challenge for this group was to add in long-term trauma recovery services, which have not traditionally been the focus of domestic violence programs.

Portal Project
New York City, New York

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The Portal Project in NYC is housed at a comprehensive social service agency, Project Return Foundation (PRF) that provides substance abuse services for both women and men (one residential treatment program for women and children, and one co-ed residential program). The Portal Project worked closely with a local domestic violence agency during Phase I to enhance cross training and referrals. The grant no longer focuses on the domestic violence component, but there is an ongoing relationship between the two agencies. PFR has its own domestic violence support groups for women. One of the challenges faced by this site is the integration of trauma services for women in the co-ed program. They are also utilizing the Seeking Safety model (Najavits, L., 2001) for designing interventions for women with histories of trauma who are using alcohol and other drugs. Cross-consultation and case discussions are key aspects of their integrated model, and services are strongly informed by survivor graduates.

Collaborative Projects
for Children Who Witness Violence

A number of efforts are underway throughout the United States to address the impact of witnessing domestic violence on children's mental health. Two of these initiatives feature partnerships between individual domestic violence agencies and mental health providers. Both projects are funded by grants. Two others are well-established programs within academic medical settings. Each provide mental health services for children who witness domestic violence and other forms of violence, and provide services for the children's families. Both work collaboratively with domestic violence programs. Another project involves a countywide consortium of domestic violence advocates and child therapists, housed in the Department of Community and Human Services. The last three projects are part of federally funded multi-site studies, or initiatives that address childhood trauma more broadly.

***The Homeless Children's Network
San Francisco, California***

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The Homeless Children's Network (HCN) is a consortium of fifteen homeless and domestic violence programs designed to address the traumatic effects of homelessness on children. Founded in 1992, HCN provides therapy and case management support to homeless children and their families. Clients are seen for individual counseling, play therapy, and family and group therapy on both a short-term and long-term basis. Therapists are available during day and evening hours on-site at HCN, in shelters, and in schools. HCN also provides After Care services to support families' continued independence and strength once they achieve stable housing. As the largest collaborative in San Francisco providing mental health support to homeless families, HCN facilitates networking for public and private community agencies such as schools, community centers, advocacy groups, health clinics, mental health agencies, child care facilities and shelters.

A key feature of this project is that children continue to receive services as they move from shelter to shelter and into transitional and independent housing. This allows them to continue working with one therapist over an extended period of time. For a number of children, the therapist may be one of the few points of consistency in their lives.

***Child Development Community Policing Program: Child Study Center and New Haven Department of Police Service: Yale University School of Medicine
New Haven, Connecticut***

**Yale University Child Study Center
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The Child Development Community Policing Program (CDCP) represents a unique collaboration between developmental child mental health professionals, police, and domestic violence advocates. It provides 24-hour consultation to the police for any child or family for whom there is concern about trauma exposure. Approximately one third of these situations involve domestic violence. Clinical work is similar to other child witness to violence programs, but entry into treatment is different. In this program, most cases are referred by the police, and coordination is maintained among police, advocates, and clinicians.

A therapist is always on call to go to a scene in which children have been exposed to violence to talk with both the parents (mothers, in the case of domestic violence) and the children. Advocates on the staff of the Child Study Center are also available to respond immediately or the next day, at the request of the on-call clinician and the battered woman. In addition to crisis counseling, clinicians and advocates assist with physical safety planning and with finding a safe place for the women and their children to stay. Advocates help women with housing, obtaining benefits, and becoming knowledgeable about court procedures. The program also maintains close links with court-based advocates. Continued coordination with the police often facilitates this process.

Interventions at the scene involve finding out what the children saw and about their prior history, briefly assessing children's responses to the incident through semi-structured clinical interviews and drawings, providing psychoeducational information to mothers regarding children's likely responses to violence and trauma, and offering formal evaluation and treatment for the children. Sometimes a single therapist will work with both mother and child. In other cases, someone from the team provides services to the mother while the child is being seen. Some women choose to obtain treatment for their children but not for themselves, though many women who decline clinical treatment do maintain contact with the program's advocates. Women with more serious mental illnesses are referred to the public mental health system, but the program does maintain contact around the children's needs. Although the CDCP program is primarily a collaboration between the police and the Child Study Center, it does work collaboratively with one domestic violence agency in New Haven to provide mental health services to children of mothers in their programs.

An additional component of the program pairs outreach advocates with neighborhood police officers to conduct follow-up home visits to households where an incident of domestic violence has been reported. The purpose of the visits is to monitor and address safety concerns, provide additional information about court processes, and facilitate access to other social services, including mental health evaluations and treatment for children and mothers. An evaluation of the program is in progress.

**Children's Therapy Project: Illinois Coalition Against Domestic Violence
Springfield, Illinois**

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The Children's Therapy Project provides Illinois domestic violence programs access to a pool of funds to subcontract for children's mental health services from licensed professionals in their communities. Although many programs report that the funds are inadequate to respond fully to all the need they see, they are enthusiastic about the project for a number of reasons. The revolving fund for mental health evaluation and therapy for child witnesses enables the most needy children to get immediate, specialized

help while the window of opportunity to intervene exists. Prior to this grant, these children were identified by domestic violence staff, but they could not access the necessary help because of long waiting lists or insufficient financial resources. The grant has also enhanced the assessment and clinical skills of domestic violence program staff through the case and staff consultations delivered by child mental health specialists.

This project provides evaluation and therapy for children exhibiting emotional and behavioral disturbances and developmental delays. FY01 total statistics are as follows:

VOCA Special Projects: Children's Therapy Project	
Service Summary	
NUMBER OF CHILDREN	
Duplicated Number of Children Served:	2851
Duplicated Number of Children--Evaluation:	241
Duplicated Number of Children--Therapy:	1527
Duplicated Number of Children--Group:	1276
Duplicated Number of Children--Case Consultation:	335
Duplicated Number of Children--No Show:	249
NUMBER OF HOURS	
Evaluation Hours Provided:	291.75
Therapy Hours Provided:	2991.28
Group Hours Provided:	764.85
Case Consultation Hours Provided:	268.38
Staff Consultation Hours Provided:	162.75
No Show Hours:	240.55
Total Hours Provided:	4691.56

In FY01, an average of 238 clients per month were served. This project is successfully meeting its objectives, and as intended, the vast majority of the funds are paying for therapy. Due to a lack of data collection in the InfoNet, unduplicated client numbers are unavailable at this time.

Programs have reported that the availability of these funds makes an enormous difference in the lives of children. Last spring ICADV surveyed the programs for feedback about their experiences with the children's therapy grant. For specific examples of the project's benefits, see Appendix A. ICADV's recent expansion of this program will fund a full-time child therapist position for each of 12 selected domestic violence agencies.

Child Witness to Violence Project, Boston Medical Center

Boston, Massachusetts

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The Child Witness to Violence Project (CWVP) is a clinical program designed to assist children who witness violence, and in the case of domestic violence, their non-abusive parent, generally their mothers. It is housed in the Department of Pediatrics at Boston Medical Center (BMC) and has been in existence for nine years. During this time, the project has developed extensive collaborations with domestic violence programs, the Boston Police Department, the courts, and the child protective service system. It provides advocacy and case management as well as therapy.

In both the Yale and BMC programs, treatment is geared toward the children, but it involves the parents as well. Comprehensive in their approach, staff members maintain contact with teachers and day care providers, make home visits, go to court with the women, and interface with the police. In addition, CWVP has developed a curriculum for mental health clinicians that work with children affected by domestic violence and another curriculum for early childhood providers working with children affected by domestic violence. The Project has provided training to judges to raise awareness of the child's perspectives in custody decisions.

CWVP is involved in the collaboration between the Massachusetts State Department of Social Services (DSS) and domestic violence programs to place domestic violence advocates on staff in child welfare agencies. This has reduced some of the tensions that have existed between child protective services and domestic violence advocates and has facilitated a system in which both mothers' and children's needs are taken into account. Another outgrowth of the CWVP's collaboration with DSS has been the development of nine new child witness projects throughout the state, funded by DSS. These programs are collaborations between community mental health centers and domestic violence advocacy programs, and they offer counseling services to women and children affected by domestic violence. The CWVP provides consultation and technical assistance to these projects.

*Peace, a Learned Solution (PALS): Providence House/Willingboro Shelter
Willingboro, New Jersey*

Providence House/Willingboro Shelter
Jean L. Metz, ACSW, LCSW, Division Director
P.O. Box 496
Willingboro, New Jersey 08046
Office: 856-824-0599
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jmetz@cctrenton.org
<http://www.catholiccharitiestrenton.org/divisions/providencehouse.html>

Peace: A Learned Solution (PALS), a program of Providence House of Catholic Charities—Diocese of Trenton, is the designated lead agency that provides domestic violence services in Burlington County. PALS was designed as a pilot research project funded by the State of New Jersey Department of Human Services, Division of Youth and Family Services (DYFS). This specialized pilot program assesses and treats children exposed to domestic violence as either victims or witnesses whose parents are receiving domestic violence protective or supportive services.

PALS services to about 40 children each year include:

- comprehensive assessments
- day care
- before and after school programming and summer camp (as appropriate)
- case management
- group and individual art, play, drama, and dance/movement therapies
- educational support
- follow-up services
- transportation

To complement these services, PALS also provides individual therapy to the non-offending parent. This is a particularly important component of the program designed to teach the non-offending adult effective parenting techniques and integrate the therapeutic learning into the home setting. All PALS services are provided at no cost to the client.

A child participating in the PALS program receives intense therapeutic and case management services for a period of six months. The PALS program caseworker meets with the non-offending parent on a weekly or bi-weekly basis (as needed) to assist family members with their daily living needs and to coordinate the services provided, namely therapy and child care. Each child also receives two therapeutic sessions per week.

The therapeutic interventions used at PALS are geared toward addressing the child's anxiety, depression, anger, aggressive tendencies, social interactions, scholastic performance, and self-esteem problems stemming from the abuse that was experienced or witnessed. However, the interventions are child centered and allow the child to raise specific issues based on his or her individual case. The drama therapy and art therapy rooms are equipped with many materials that allow the children to use their creativity and engage in fantasy play. PALS focuses on the child and his/her development and future successes, as well as emphasizing the importance of parent-child relationships.

Regional Projects *for* Children Exposed To Domestic Violence

**King County Women's Program
Department of Community and Human Services**

**Carole Antoncich
821 2nd Avenue, Suite 500
Seattle, Washington 98104-1598
Phone: 206-296-5241
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**carole.antoncich@metrokc.gov
www.metrokc.gov/dchs/csd/Women**

The Children's Domestic Violence/Mental Health Project is a network of children's therapists and domestic violence advocates. The network is organized and managed by the King County Washington (Seattle) Community Services Division—Women's Program. Initiated in 1995, the project seeks to improve services to children affected by domestic violence. An advisory group whose members represent both the domestic violence and mental health systems oversees the project.

The original objectives of the project were to:

- develop protocols for children's mental health and domestic violence victim service programs;
- increase the capacity of staff in those programs to meet the needs of children affected by domestic violence; and
- encourage collaboration across the two fields.

Since 1995, the project has established a network of children's mental health providers and domestic violence advocates that meet monthly. These meetings frequently feature case studies and cross-disciplinary problem solving. Meetings also provide a forum for discussions and in-service training related to issues of mutual interest, especially those that tend to create friction between the two systems, such as confidentiality. According to the coordinator of the project, an important benefit from these meetings is their role in demystifying the workings of each system. For example, it is helpful for mental health providers to understand what goes on in shelters and what kinds of services are provided there. Likewise, it is important for advocates to gain a better understanding of what happens in psychotherapy with children and how mental health agencies operate. The meetings facilitate this kind of cross-disciplinary learning.

Additionally, the project has produced an internal consultation list of network members who agree to provide informal consultation. This list is a resource for individual service providers who may need information or assistance on a case-to-case basis. Finally, the project provides multiple training opportunities. In addition to the in-service trainings that are a component of the monthly network meetings, the project has provided eight larger trainings attended by a total of nearly 800 people, on topics such as assessment of chemical dependence and domestic violence, batterers and their children, and family violence and teens.

Project participants were surveyed in 1999 as part of an informal evaluation. Findings suggest that the project is effective in important areas. For example, 65% of respondents said that, as a result of participation in the network, communication was clearer or much clearer with providers in the other system. With regard to the larger trainings, 80% of respondents said they were more likely or much more likely to provide appropriate services within their own system to children affected by domestic violence.

**Federally Funded Collaborative Programs
for Children Who Witness Violence**

Several notable federally sponsored child witness to violence projects will be described in future editions of this report. They include the Children’s Subset Study of SAMHSA’s Women, Co-Occurring Disorders, and Violence Study; the Department of Justice’s Safe Start Initiative; and the SAMHSA/Center for Mental Health Services’ National Child Traumatic Stress Initiative (NCTSI).

The Childrens Subset Study – SAMHSA

The SAMHSA Child Subset Study is unique in its effort to address the effects of parental alcohol, drug, and mental health problems, as well abuse and violence-related trauma, on children whose mothers are seeking mental health or substance abuse services. Each of the four sites in the Study— Prototypes, New Directions for Families, W.E.L.L., and Allies in Northern California—performs uniform parent and child interviews and provides ongoing case management, including family therapy, day care, psychiatric interventions, referrals for school, medical and social service, and a skills building group intervention based on a modified version of *Groupwork with Children of Battered Women* (Peled and Davis, 1995).³ Other services include a range of therapeutic and educational activities to improve parenting, such as W.E.L.L.’s Nurturing Program for Families in Substance Abuse and Recovery that incorporates issues of mental illness and trauma into structured parent-child activities. Some programs also provide play therapy, after school programs and strength-based coordinated parent-child case management. Early reports indicate that these models are working well. All these sites emphasize integrated family-centered approaches to addressing childhood trauma.

The Safe Start Initiative

The Safe Start Initiative, funded by the Dept. of Justice Office of Juvenile Justice and Delinquency Prevention (OJJDP), is a 5½-year demonstration project providing support for 9 urban, rural, and tribal communities to address the issues faced by young children exposed to violence within their homes, schools, and communities. The initiative creates an opportunity for sites to implement coordinated community-wide and community-driven prevention and intervention strategies. These strategies would reduce the effects of children’s exposure to violence by strengthening existing alliances and integrating service delivery systems such as police, child care, school, health, mental health, and juvenile justice. The National Civic League provides training and technical assistance for the project.

The Safe Start Initiative web address is: <http://www.nceev.org/programs/safe-start/index.html>

NCTSI’s National Center for Traumatic Stress, established by Duke University and the University of California at Los Angeles (UCLA) will coordinate the Initiative’s efforts to expand services, raise the standard of care for traumatized children, adolescents, and their families, and oversee a nationwide collaborative network of organizations involved in the study, treatment and support of children and families impacted by traumatic stress. Three of the five Service/Treatment Development Centers funded by this Initiative involve programs that specifically address the traumatic effects of domestic violence on children, including the Yale Child Study Center described above.

³ Peled E. and Davis D., (1995). *Groupwork with Children of Battered Women: A Practitioner’s Manual*. Thousand Oaks, CA: Sage Publications, Inc.

National Child Traumatic Stress Initiative – SAMHSA

The Early Trauma Treatment Network, housed at the University of California-San Francisco, is a four-site collaboration between UCSF's Child Trauma Research Project, the Violence Intervention Program for Children and Families at Louisiana State University's Health Sciences Center, the Tulane University Medical Center, and the Child Witness to Violence Project at Boston Medical Center. It will provide expertise in implementing, evaluating and improving trauma treatment approaches for families with young children, zero through six years of age. Trauma service approaches will be developed and tested for ethnically/culturally diverse children and families traumatized by interpersonal violence and sudden loss. The child-parent psychotherapy model is a manualized, multimodal relationship-based treatment that integrates psychodynamic, developmental, and supportive modalities, and was initially developed for children exposed to domestic violence (Alicia Lieberman, Ph.D., Child Trauma Research Project⁴). This child-parent model will be evaluated among culturally diverse groups at all four sites.

The Northshore University Hospital, Long Island, N.Y., will coordinate development of treatment and service approaches for adolescent trauma survivors, including adolescents who experience domestic violence.

Curricula *and* Training Materials

Practice Guidelines

Currently there is a dearth of curricula that specifically address the mental health needs of domestic violence survivors and their children. Several *practice guidelines* do exist for addressing domestic violence in mental health settings. They do not attend to treatment per se; rather they focus on understanding the dynamics of abuse and the particular dangers (e.g. custody, credibility, and confidentiality) women face in accessing mental health services. They address issues of identification, assessment, intervention, safety planning, appropriate documentation, and referrals to domestic violence agencies. Some also provide guidance to clinicians working with perpetrators of abuse, a topic not covered here but clearly a priority issue (Schechter, 1995; Jordan et al., 1998). The guidelines include:

Guidelines for Mental Health Practitioners in Domestic Violence Cases, Schechter, S. 1987, published by the National Coalition Against Domestic Violence, Washington, D.C. For copies contact: National Coalition Against Domestic Violence, P.O. Box 18749, Denver, CO 80218; Phone: 303-839-1852.

Recommendations for Addressing Domestic Violence in Mental Health Settings, Warshaw 2002, published by the Domestic Violence and Mental Health Policy Initiative in Chicago, IL (gmoroney@hektoen.org , or ginsburj@yahoo.com or jginsburg@dvmhpi.org).

Mental Health Interventions in Cases of Domestic Violence, Jordan, Quinn and Walker, (1998) Governor's Office of Child Abuse and Domestic Violence Services, Lexington, Kentucky. This comprehensive document is available at: www.state.ky.us/agencies/gov/domviol/mhcurri1.htm The document includes an in-depth discussion of legal issues specific to the state of Kentucky. It could serve as a model for other states interested in developing similar curricula.

Treatment Recommendations

In addition, a number of books and book chapters delineate treatment recommendations for mental health professionals working with battered women that bridge treatment and advocacy concerns. These include:

Empowering and Healing the Battered Woman: A Model for Assessment and Intervention, Dutton, M.A., (1992). New York: Springer.

Abused Women and Survivor Therapy: A Practical Guide for the Psychotherapist, Walker L., (1994). Washington, D.C.: American Psychological Association.

Women and Violence, Warshaw, C. (2001). In Stotland and Stewart (eds.) *Psychological Aspects of Women's Health Care*. Washington, DC.: American Psychiatric Press, Inc.

Information from these documents easily could be incorporated into training for domestic violence or mental health service providers.

Continuing Needs

Basic *curricular materials* are still needed to train mental health providers in the dynamics of domestic violence, integrating appropriate responses into current practice, guidelines for documentation, confidentiality and information sharing, making appropriate referrals, working collaboratively with local domestic violence agencies, and cultural issues confronting battered women from diverse communities.

Curricula are needed to assist domestic violence advocates in understanding the traumatic impact of both current and past abuse and in recognizing when women have mental health needs that would benefit from clinical intervention.

Developing integrated curricula and cross-training models that address the mental health and advocacy needs of battered women will be critical to providing comprehensive and collaborative service delivery. Cross-training would allow mental health providers to facilitate the healing and recovery process while also attending to women's needs for safety and confidentiality.

A critical need also exists for training materials that integrate *empowerment-based trauma theory and culturally sensitive treatment models* with the *issues faced by women experiencing current abuse by a partner*. Many battered women experience multiple forms of abuse throughout their lives, putting them at even greater risk for posttraumatic mental health problems and potentially affecting their ability to mobilize resources necessary to protect themselves and their children. Models that address trauma in the context of ongoing domestic violence are still in the developmental stage and are not widely integrated into domestic violence or mental health training or practice.

Women dealing with *serious mental illness* are even more vulnerable to abuse—by partners, family members, caretakers, staff, and residents of shelters and housing facilities, and by other members of their support networks. Yet, training materials specifically designed to address domestic violence in the context of severe mental illness have not yet been developed. Guidelines are needed both to assist domestic violence programs in responding to the needs of women with serious mental illness and for the public mental health system, whose services are primarily targeted toward working with this group of women.

Curricula are needed that address the developmental and mental health needs of children who witness and experience violence and that are supportive and respectful of mothers as well. The majority of shelter residents are children, yet few shelters have well-developed services for children. Groups are often ineffective for young children, yet shelters that do have services for children often only have the resources for this modality. Traditionally, mental health providers have not addressed how a mother's experience of abuse affects her children and what would be most helpful to both. Child protective services and the juvenile courts can be more punitive toward mothers than toward perpetrators, often on the misguided assumption that women willingly fail to protect their children. Support for existing child witness and exposure-to-violence programs to develop domestic violence specific curricula for advocates and mental health providers would greatly enhance their capacity to offer thoughtful, developmentally informed services to children and their mothers.

Shelter from the Storm (Groves, undated)⁵ is a manualized curriculum for trained child mental health providers, while Groupwork for Children of Battered Women (Peled and Davis, 1995) offers a guide for conducting groups in domestic violence programs. Both are reviewed below. The new Children's Subset Study of the SAMHSA Women and Violence Project, the SAMHSA/CMHS National Child Traumatic Stress Initiative, and the Department of Justice's Safe Start program should provide important insights into best practices and effective training to address the trauma and domestic violence-related mental health needs of both children and their non-abusing parents.

Work also must be done to insure that curricula are sensitive to women from a wide range of cultures and communities. Stigma is a significant barrier for battered women in addressing mental health needs, and a

⁵ Child Witness to Violence Project, Boston Medical Center, Pediatrics.
<http://www.bostonchildhealth.org/special/CWTV/resources.html>

woman's cultural background often influences how she perceives issues related to mental health. In addition, many cultures have healing traditions that do not fit typical mental health models. It will be important to learn more about how these traditions could be incorporated into shelters and mental health settings. Programs that have developed culturally specific models for addressing domestic violence and its mental health consequences provide important insight into what women experience as healing and empowering. Providing a forum for exploring these issues across cultures and identifying a range of sensitive models will hopefully contribute to ongoing work in this area. While cultural sensitivity and cultural competency are critical for providers in any setting, developing culturally specific models for addressing trauma in the context of domestic violence requires additional depth and understanding of what is healing to people from a diverse range of ethnic, spiritual and cultural communities.

Responding to the Need

Several of the SAMHSA Women and Violence sites are designing interventions specifically for women struggling with domestic violence, lifetime trauma, substance abuse, and mental illness that should lead to best practice models and new curricula. Elizabeth Stone House's *Sheltering People in Emotional Distress* provides some preliminary guidance on these issues. The domestic violence module of Maxine Harris' *Trauma Recovery and Empowerment (TREM)* curriculum also offers a way trauma group leaders can help multiply-traumatized women develop tools for identifying safe relationships.

Ideally, training curricula for mental health and substance abuse service providers that approach the psychological impact of abuse from a trauma perspective *and* address domestic violence, safety, legal issues, and advocacy issues will emerge over the next several years. Parallel curricula should be developed for domestic violence advocates that prepare them to identify and respond to issues of mental health, trauma, and substance abuse. Training materials should provide basic information about both service delivery systems, as well as guidelines for creating culturally sensitive trauma-informed services and for developing collaborative community responses to mental health issues, substance abuse, and domestic violence.

No comprehensive curricula specifically prepare advocates or clinicians to work with domestic violence survivors who are dealing with trauma-related mental health issues or with each other, but there are a number of relevant manuals and guidelines that lay the groundwork for more specific training curricula for mental health, substance abuse, and domestic violence service providers. The DCPD/DVMHPI has identified a number of manuals, resource books, and guidelines that are relevant to these issues. The following publications have been reviewed by DCPD/DVMHPI staff.

Crossroads Cross-Training Manual. Wisconsin Department of Health and Family Services, 2000. Members of the public can get this document by contacting Curtis D. Wittwer, Training Coordinator, Room 550 Box 7851, 1 West Wilson Street, Madison, WI 53707-7851 at (608) 267-4896 VOICE, (608) 264-9832 FAX, or wittwcd@dhfs.state.wi.us ; Division of Support of Living, Wisconsin Dept of Health and Family Services, Madison, Wisconsin. Request Document No. PSL-3162.

This 454-page manual provides an overview of the basic philosophy and perspectives in the mental health, substance abuse, domestic violence, and sexual assault service areas. It is not designed for training in the provision of specific services, but rather serves as an introduction to issues awareness and systems collaboration in trauma services for persons with mental health and/or substance abuse issues. It includes a section on the history, principles, and themes of the mental health consumer/survivor movement. This

manual lays the groundwork for developing more specific training curricula for mental health, substance abuse, and domestic violence service providers.

Video: Meeting at the Crossroads. Crossroads Training Conference and Trauma Workgroup
<http://www.sidran.org/catalog/wime.html>

Available online at Sidran Traumatic Stress Foundation website www.sidran.org. Search Sidran Bookshelf for *crossroads*.

Meeting At The Crossroads is the first video of its kind to raise awareness of the importance of collaboration between mental health and other agencies regarding trauma issues. It is intended for mental health, substance abuse, domestic violence, sexual abuse, and sexual assault providers, national consumer and advocacy groups, and legislators. Portraits of survivors interweave with discussions by counselors, program directors, advocates, and others for an engaging and motivational look at the differing ways in which providers of mental health, substance abuse, domestic violence, and sexual abuse and assault services address the issues of trauma. *Meeting At The Crossroads* advocates collaboration among all service providers in helping trauma survivors. The video emphasizes the concepts of empowerment and recovery of the whole person, promotes commitment to systems change, and conveys the importance of collaborative efforts.

Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines on Policy and Practice; Recommendations from the National Council of Juvenile and Family Court Judges Family Violence Department. Susan Schechter and Jeffrey L. Edelson (primary authors). Family Violence Department of the National Council of Juvenile and Family Court Judges, 1999, PO Box 8970, Reno, NV 89507. 1-800-527-3223. <http://www.dvlawsearch.com/pubs/>

Also known as the Green Book, this volume of recommendations focuses on three primary systems: the child protection system, the network of community-based domestic violence programs, and the juvenile or other trial courts that have jurisdiction over child maltreatment cases. The recommendations do not specifically address the mental health system, but they are entirely relevant.

The Elizabeth Stone House Handbook: Sheltering People in Emotional Distress
\$29.95 plus \$3.50 for postage. Elizabeth Stone House, Publications, P.O. Box 59, Jamaica Plain, MA 02130, (617) 522-3659 ext. 208.

<http://www.elizabethstonehouse.org/out.htm>

Sheltering People in Emotional Distress is a "how to" handbook for developing community-based residential mental health alternatives. It includes residential programming as well as information on advocacy and crisis intervention, offering practical recommendations for dealing with specific situations that may arise in sheltering women with a history of mental illness or trauma-related mental health needs. The Handbook straightforwardly discusses ways to create a mutually respectful empowering environment and the importance of dealing with provider fears and stigma associated with mental illness. It also provides guidance on setting up a nonprofit organization.

Groupwork with Children of Battered Women: A Practitioner's Manual

Einat Peled and Diane Davis
Thousand Oaks, CA
Sage Publications, Inc., 1995
<http://www.sagepub.com/>

Groupwork with Children of Battered Women: A Practitioner's Manual provides a detailed description of how to conduct a ten-week group intervention for children of women who are or have been abused by an intimate partner. This model is based on the experience of the children's program at the Domestic Abuse Project in Minneapolis and on a qualitative evaluation of that program. The major goals of the 10-session format are for participants to be able to talk about the abuse they have experienced in a safe supportive environment; to reduce shame, isolation and self-blame; to learn to express feelings in healthy ways; to protect themselves without becoming abusive; to have a positive shared experience and to strengthen their self-esteem. The authors acknowledge that while the groups were healing for many, they can also increase a child's stress. Clear guidelines are provided for determining whether or not to recommend groupwork for a particular child and how to best involve the parent or parents in this process. Parent and developmentally-appropriate child intake and assessment forms are included in the appendix and instructions for facilitating 10-week parenting groups are offered as well. These groups are not intended for children with more severe emotional symptoms or for children who have been physically or sexually abused and not been treated.

Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse. **Karen Saakvitne, Ph.D., Sarah Gamble, Ph.D., Laurie Anne Pearlman, Ph.D., and Beth Tabor Lev, Ph.D.** The Sidran Press, 1999.
<http://www.sidran.org/catalog/trrc.html>

Risking Connections is a trauma treatment curriculum written for providers of mental health and substance abuse services by trauma specialists at the Trauma Research, Education and Training Institute, Inc. (TREATI) of South Windsor, Connecticut with the support of the Departments of Mental Health in the states of Maine and New York. It was designed specifically for clinicians working in the public mental health system but is applicable to a wider range of settings. The project was guided by an advisory board, which included consumer/survivors as well as community mental health providers. The curriculum is written in five modules:

- Understanding Trauma
- Using Connections
- Keeping A Trauma Framework
- Working With Dissociation
- Vicarious Traumatization

Each module can stand alone. The foundation of the model is relational, and it is most appropriate for use by trained clinicians.

Because the focus is on survivors of childhood abuse, the program does not address the legal and safety issues that are central to interventions with domestic violence victims, although it does address the risk of self-harm. Certain features of the manual will be important in developing curricula specific to domestic violence, especially the centrality of the trauma framework, the importance of understanding clients and their symptoms in the context of their life experiences and cultures, and the attention to vicarious traumatization and other provider issues. This curriculum provides a complex in-depth approach to working with trauma survivors in a very accessible format. It also provides tools that survivors can use to

assist them in the process of healing. The Sidran Foundation is working in collaboration with DVMHPI in Chicago and the House of Ruth in Baltimore to adapt the curriculum to address trauma in the context of domestic violence.

***Shelter from the Storm: Clinical Intervention with Children Affected by Domestic Violence. A curriculum for mental health clinicians.* Betsy McAllister Groves (undated). Child Witness to Violence Project. Boston Medical Center, Boston, MA.**
<http://www.bostonchildhealth.org/special/CWTV/resources.html>

Shelter from the Storm is a 236-page manual for training child mental health clinicians who work with families and young children affected by domestic violence. It is written by the senior staff of the Child Witness to Violence Project at the Boston Medical center and is drawn from the extensive clinical training they have provided in more than 25 states. It is designed for use by trainers who are experienced child mental health clinicians.

The manual provides information and case examples that illustrate the complexities of working with families affected by domestic violence. It contains six flexible training modules for 13 hours that can be delivered as a two-day session or used in six separate sections. It also includes a computer disc containing 115 Power Point slides that provides the essential information for each of the six modules:

- Domestic violence: Principles of empowerment-based practice
- The impact of domestic violence on children
- Assessment of children affected by domestic violence
- Individual and group treatment of children affected by domestic violence
- Domestic violence, children and the court
- Caring for the caregiver

The cost of the manual is \$125 plus shipping and handling.

***Trauma Assessment and Treatment Resource Book.* New York State Office of Mental Health Trauma Initiative, 1998. 518-474-2578 or jchassman@omh.state.ny.us**

An important component of the New York State Trauma Initiative is the establishment of trauma workgroups at each state psychiatric center. This book includes the products of those workgroups: model assessment forms, curricula for trauma treatment in groups, trauma-related policies and procedures, and model restraint reduction programs. This book contains very little theoretical instruction. Rather, it is a collection of documents that can serve as tools for improving an agency's capacity to identify and respond effectively to trauma survivors. The documents do not specifically address domestic violence.

***Trauma, Recovery and Empowerment: A Clinician's Guide for Working in Groups.* Maxine Harris, Ph.D. and the Community Connections Trauma Work Group. The Free Press, 1998.**

Trauma Recovery and Empowerment is a curriculum for working with highly vulnerable trauma survivors in groups. It was developed to respond to the need for a treatment model for trauma survivors who live "on the social, emotional, and economic margins." Unlike the other group curricula described above, this group model is intended as the primary intervention for healing and recovery, and it takes a very practical, hands-on approach to trauma work. The curriculum covers 33 topics, each of which is

presented with a clinical rationale, a list of goals, a set of questions for discussion, and an experiential exercise. A video accompanies the curriculum.

This curriculum is not specifically focused on domestic violence but does address current abuse in women's lives, which may be from a partner or from another member of a woman's network. An additional 10-week domestic violence module has been developed for survivors of childhood sexual abuse who have been re-victimized as adults. The module was designed as an extension of TREM work, rather than a vehicle for addressing the immediate advocacy issues faced by women currently in danger from an intimate partner.

The author initially cautioned against making modifications to shorten the 33-week curriculum or to change its focus from recovery to psychoeducation, although 4 and 24 session modifications are currently being tested. The curriculum is presented in a format that could realistically be offered in community mental health centers. It could be expanded to include domestic violence issues or could be complemented by domestic violence education and support. Because of the length of the program, it is not feasible for most domestic violence shelters in its original form, though it could be offered on-site at domestic violence walk-in or transitional housing program in collaboration with a trained clinician. Specific group sessions could also be incorporated into shelter programming.

The Trauma Safety Drop-In Group: A Clinical Model of Group Treatment for Survivors of Trauma. **Patricia A. Gilchrist, CSW and Peri L. Rainbow, MPS. New York State Office of Mental Health Trauma Initiative. 518-474-2578, jchassman@omh.state.ny.us**

This short manual prepares trained therapists who are already familiar with trauma theory to facilitate a Trauma Safety Drop-In Group which is intended to respond to the safety needs of trauma survivors and to help survivors recognize and strengthen the safety skills they already have. Additional goals include increasing the survivor's ability to function and feel safe in a more intensive level of group treatment, learning about the healing process and the aftereffects of trauma, and assessing readiness for further treatment. The group is conceived as a complement to individual psychotherapy. It is structured so that survivors can join at any point and complete the cycle at their own pace. This model could be adapted to address some of the specific concerns of domestic violence survivors and could be offered both in mental health centers and in advocacy programs.

Understanding and Dealing with Sexual Abuse Trauma: An Educational Group for Women. **Kristina Muenzenmaier, MD, Donald E. Sampson, Ph.D., CRC, NCC, Lisa Norelli, M.D., Katherine Ann Alexander, R.N., M.S., Barbara Stephens, R.N., M.S., and Heather Huckeba, CSW. New York State Office of Mental Health, Trauma Initiative, 1998. 518-474-2578, jchassman@omh.state.ny.us**

This curriculum presents an educational model for group work with female survivors of sexual abuse. Rooted in trauma theory, it is intended for women with severe mental illness, but it was originally adapted from a model for women with less severe illnesses. This model is not a replacement for individual therapy. While it does not specifically address domestic violence, it could be used as a framework for developing psychoeducational groups about the mental health impact of domestic violence.

Bridging the Systems to Empower Victims, Mental Health and Victim Services. **Pennsylvania Coalition Against Rape, Office of Victims of Crime. 1996 (2000, reprint).**

Instructor manual: <http://www.ojp.usdoj.gov/ovc/publications/infores/vestmtl/welcome.html>

Student manual: <http://www.ojp.usdoj.gov/ovc/publications/infores/student/welcome.html>

This resource manual contains a collection of articles and information written from the perspective of either a mental health service provider or a victim service provider. It is not a theoretically integrated curriculum, and the perspectives represented are not always in agreement. The manual is broad in scope and applicable to victims of all types of violent crime, but it includes a section entitled “Hostage in the Home” that addresses domestic violence. Like the manual described below, Bridging the Systems provides a foundation to begin thinking about developing integrated training models for advocates and for mental health and substance abuse service providers.

Additional relevant materials will be reviewed in future versions of this report.

Conclusion

The programs and initiatives highlighted in this report represent important steps toward bridging the gaps between the domestic violence and mental health communities—gaps through which too many women and children have fallen. Large-scale state or community-wide partnerships between domestic violence and mental health providers are still relatively few in number, but many smaller focused initiatives are doing important collaborative work. More and more, advocates and mental health providers are beginning to recognize the profound mental health impact of domestic violence on survivors and their children and the need for integrated services that address both past and current abuse.

Resistance still exists on both sides. Domestic violence advocates have legitimate concerns that need to be addressed about: the professionalization of a grass roots movement, focusing on individual rather than system change, the potential jeopardy that may ensue from the stigma associated with mental illness, abuser control of treatment, retaliation for seeking services, and issues related to legal credibility and custody. The mental health system is also struggling both to survive massive budget cuts and to provide basic services to its targeted constituency. Adding new services to a system that is short of resources creates significant burdens for providers. Without collaboration to address abuse and violence in the lives of people with mental illness, however, critical issues of safety and recovery will not be addressed.

Despite the problems, this is an exciting time. During the initial research for this report, there was, in fact, very little collaboration between the domestic violence and mental health communities. SAMHSA's Women, Co-occurring Disorders, and Violence Study had just started and, with few exceptions, interest from domestic violence programs was minimal. Efforts to address the mental health needs of children who witness violence were limited to a few groundbreaking programs across the country, state trauma initiatives were few and did not address domestic violence, and advocates were still reluctant to address mental health issues among the women they served. Over the past three years, the landscape has begun to change.

Advocates, while understandably cautious, are increasingly concerned about the traumatic effects of domestic violence both on adult women and on their children. In 1998 state mental health departments endorsed the National Association of State Mental Health Program Directors position statement on Services and Supports to Trauma Survivors, recognizing trauma as critical issue. While many did not have the necessary resources to mount initiatives, ten additional states have begun this process. Some have worked in collaboration with Domestic Violence Coalitions from the outset: increasingly, others have come to recognize the importance of this issue. Thus far, one state government has specifically created a mandate to train all mental health providers in domestic violence.

Models are also beginning to emerge that integrate trauma and domestic violence interventions for women with and without serious mental illness and for children whose parents are also traumatized. Some are still in their developmental phase, and much work needs to be done to refine, evaluate, and disseminate these models, to integrate them into practice, and to generate public resources that can support new comprehensive services. For example, the growing consumer-based recovery orientation of the public mental health system demands the integration of services that address both current and past abuse. On the domestic violence side, ensuring access to services that also address the traumatic mental health consequences of abuse are important next steps. Through their groundbreaking work, the sites conducting the SAMHSA Women, Co-occurring Disorders, and Violence Study provide us with models of comprehensive client-centered care. Culturally specific community-based models offer cutting-edge approaches to addressing prevention as well as intervention—critical issues that all models need to embrace as these efforts move forward.

As documented in this report, there is a pressing need for initiatives that address the mental health and substance abuse issues faced by battered women and their children. The models described in this report provide a starting point for considering possible avenues for collaboration at a range of different levels, from statewide policy initiatives to local networking arrangements to individual collaborative programs. Further work is needed to assess the capacity of existing systems to respond to those issues, to evaluate efforts such as those described above, and to provide sufficient attention and resources to achieve and sustain the type of system changes that will be necessary to meet these critical needs.

Appendix A

Contained in this appendix are the responses received from a variety of Illinois domestic violence programs surveyed by the Children's Therapy Project: Illinois Coalition Against Domestic Violence.

The survey inquired about three things:

- How is the project benefiting the children and families?
- Provide anecdotal information (specific examples) about clients who were helped.
- How is the project helping your staff and the children's program?

They (various Illinois domestic violence programs) responded:

- **The financial obstacle to professional mental health intervention is removed.**

The remarkable difference between the child that "Holly" was and the child she is now is hard to convey on paper...The child therapist's years of clinical training were one important element in the...change that occurred with this child. The agency and the family could not have afforded this level of services without this grant.

- **The customary wait of several weeks or longer for evaluation and therapy is eliminated.** Children can receive intervention almost immediately after they are identified as being in need of services. The families receive help in the small window of time available while they are in shelter.

Now children can meet with the psychologist at a place where they feel safe [the shelter] within 24 hours of being assessed.

Our contract therapist could see families quickly, whereas community resources often have waiting lists of over a month, so clients who were referred out often never made it into therapy before the end of shelter stay.

- **Professional assessments and therapy are available in a safe and familiar environment.** Many of the programs bring the professional on-site and they observe that this makes it more likely that mom will access the help.

Once a victim and her children made the big step of coming into the shelter for help, they were often reluctant to go elsewhere for ancillary services, even when in the best interest of themselves and their children. Having evaluations available for children at the shelter, clients felt more comfortable with the idea of an evaluation and it made obtaining an evaluation much more convenient than having to go outside the agency.

- **Children were more likely to continue with counseling after leaving the shelter.**

Many times when our clients leave shelter they do not choose to continue with counseling but...mother requested and continued with both her and her daughter's counseling sessions.

- **Professional assessments and therapists' testimony presented at court help the child receive the legal protection from abuse that is often denied in visitation decisions.**

*"Lisa" has three children, ages four, five, and six who ...have been enrolled in mental health services since the completion of their assessments. Lisa went to court for an extension [of her] order of protection....She told the judge she [was] trying to get her children... help through child therapy since they [were] presenting with problem behaviors as a direct result of the abuse they witnessed and experienced in the home. The judge requested the assessor's presence in court on two occasions....to report on the assessments [of the children]. Lisa was granted a two-year extension on her order of protection. On the second court date, the judge heard the assessor's report and read the letter [recommending] that it was in the children's best interest to have no visitation with their father. The judge accepted the report and indicated the abusive father would have **no visitation**. This case in itself has shown how powerful a force this service has been to our clients, as visitation is usually granted, regardless ...the severity of the abuse.*

An attorney at another program wrote:

Two of my clients that were eligible for the funds wanted their children to have supervised visits with their father. In both cases there were allegations of sexual abuse to the children. DCFS reported both complaints as unfounded and therefore made it difficult to obtain supervised visits in court. Sexual abuse is extremely difficult to identify in young children. The availability of therapy for these children strongly increases the chances that [they] will come forward with whether they were victims of sexual abuse and who the abuser was. ...[If] it has been determined that child was sexually abused, it is essential for that child to receive therapy in order to cope with this devastating tragedy. The project helps me represent these clients because if a child confides in a therapist that he or she is a victim of sexual abuse, that therapist can testify in court about this information. This information would aid me in my goal to obtain supervised visits for my client.

- **Those children with profound problems who are most in need of help can now get the services they require.**

...in the case of the 2-year-old, the screening revealed likely developmental delays and other deficiencies, which were then addressed through a variety of community and agency services. These deficiencies and delays would likely have remained undiscovered and worsened the family's problems.

One program observed that while domestic violence counseling meets the needs of most children, there are exceptions. *... mental health issues can arise for children who have witnessed domestic violence during key developmental stages....therapy is a needed service for these children.*

It was a rude awakening for staff when our contract therapists [who treat both physically and emotionally challenged children] told us we have multi-problem children, the likes of which they have never experienced. We always knew our children were special needs [kids] but put in the context of therapists who see such horrible things each day, we finally realized how affected our children were.

A thirteen-year old female sexual abuse victim who would not talk to anyone...began talking to the therapist. Finally, after eight years, she is receiving appropriate help.

- **Art therapy is highly valued as an evaluation and a therapy tool.**
(Comments are after six months of counseling.)

...though both boys were willing to come to counseling, they were [still] not open to talking about their experiences. Through art therapy ...they have to use the art as a vehicle... to share their stories.

Cody immediately identified with the art medium and began to talk about his... anger.

Children who suffer from severe behavior problems jeopardize the shelter stay for the family in addition to posing a danger to themselves and to other people. Many of these children, who have not responded to other interventions, have enthusiastically participated in art therapies. That service, combined with [others] has resulted in very marked improvements in the functioning of not just the child but of the entire family.

We have had [art therapy] groups for children as well as groups for women and children together, and have found that when families do art together it is often an opportunity for children and mothers to open their communication.... The non-threatening environment of the art sessions and the help of the consultant made it possible for the mother to listen to her child....There was a noticeable change in the child's behavior after that interaction began.

- **The Children's Therapy Project is seen as an essential piece of domestic violence programming.**

The addition of specialized funding for children's therapy has made a significant difference to the clients in our programs and its elimination would create a void in services that we would be unable to fill. We can help [children] by working closely with professionals from other fields. ...we have come to view this portion of our program as one of the most important of all of them.

... the Children's Therapy Project has been an excellent addition to our programs. It enables us to meet client needs that exceed the expertise of our staff... [Our] counselors said the consultation helped bring focus to their work and assisted them in doing thorough assessments with children early in the process. Counselors have also developed a better sense of what to expect at different developmental stages for children who have been through trauma.

This method of delivering services strengthens the working relationship between clients and staff. Parents observe the commitment of domestic violence programs to assisting them and their children when their various needs can be met.

I would like to state that I believe this project is critical in helping to prevent the children [from] returning as adult victims and/or perpetrators of violence.

