

Report on Mental Health Issues & Service Needs
In Chicago Area Domestic Violence
Advocacy Programs

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DOMESTIC VIOLENCE AND MENTAL HEALTH POLICY INITIATIVE

Report on Mental Health Issues and Service Needs in Chicago Area Domestic Violence Advocacy Programs

Executive Summary

An extensive needs assessment was conducted with domestic violence programs in Chicago and the nearby suburbs. Project staff visited each participating domestic violence program to meet with key advocates (in most cases, the program director and multiple staff persons) to assess the mental health needs and issues of battered women and their children, as well as to explore the experience of domestic violence programs interfacing with the mental health system. The interviews lasted one to two hours and were guided by a list of questions designed to promote discussion of the key issues facing domestic violence programs in meeting the mental health needs of survivors and their children. The summary below generalizes the themes, concerns, and opinions expressed in the interviews.

Primary Issues for Women in Domestic Violence Programs

- 30-90% of women in domestic violence programs have identifiable mental health problems, as estimated by participants.
- Depression is the most prevalent mental health problem for battered women in participating programs.
- Post-traumatic stress disorder, anxiety and panic disorder, and substance abuse are also common among women in participating programs.
- Battered women develop substance abuse problems as a way of coping with violence.
- Staff observe the effects of witnessing violence among many children of battered women, including abusive behavior towards the mother (especially among boys).
- A large proportion of women in participating programs have experienced multiple forms of trauma throughout their lives.

Current Practices and Services

- Counseling services provided in domestic violence programs are generally limited to domestic violence counseling (which may include education about abuse and the dynamics of domestic violence, validation and support, safety planning, and assistance accessing needed resources).
- Participating domestic violence programs do *not* use mental illness as an exclusionary criterion, provided women are stable and adhere to treatment recommendations.

Mental Health Issues & Service Needs in Chicago Area DV Advocacy Programs

- Participating programs are seeing increasing numbers of women with mental health problems.
- Many programs have developed relationships with local mental health agencies, private practitioners, and/or psychiatric teams from Beacon or Thresholds, but still do not feel prepared to successfully navigate the mental health system with their clients.
- Most programs make referrals to their local community mental health center.

Concerns About the Mental Health System

While some programs reported positive experiences interfacing with the mental health system, advocates are generally concerned about the care battered women receive in that system, and point to discrepancies in quality along socioeconomic, race, and gender lines.

Practical concerns

- Referral process takes too long
- Treatment criteria and catchment areas are confusing
- Scant availability of affordable services; complicated by managed care/insurance issues and cost of psychiatric medications.
- Cultural barriers

Other concerns stem from advocates' view that the mental health system fails to recognize and respond to the social conditions that condone and perpetuate abuse:

Philosophical concerns

- DSM diagnoses fail to capture the social underpinnings of abuse, pathologize battered women, and create special risks.
- Psychotropic medications are too frequently not offered in conjunction with other important services.
- Many mental health providers recommend couples counseling even though it is generally contraindicated in abusive relationships.
- Some batterers are able to use the mental health system as an instrument of control over their partners.
- Importance of advocacy work is largely unrecognized not always respected by mental health professionals.

Other Barriers for Battered Women Accessing Mental Health Services

- Stigma associated with accessing mental health services
- Dearth of multi-lingual, culturally sensitive services
- Fear of DCFS (Child Protective Service) involvement

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- Legal issues (mental health issues may be used against woman in divorce or custody proceedings or to undermine her credibility in court)

Related Concerns

- Vicarious traumatization and burnout are common among domestic violence program staff.
- Pastoral counseling frequently has a detrimental effect on women's well-being and safety.
- Many programs have concerns about how the professionalization of DV program staff will affect the peer-support/empowerment/grassroots focus of the advocacy community.
- Cultural issues and the need for culturally sensitive services.

Initial Suggestions

- Improve service access and availability through partnerships/linkage agreements with local mental health agencies and providers
- Cross-training
- Communication and consensus building with mental health providers
- Increase resources to allow programs to provide or access mental health services with clinicians who understand domestic violence
- Activism

INTRODUCTION

Despite the tremendous impact that traumatic victimization and on-going abuse can have on the emotional well-being of women and children, collaborative models for addressing these issues have been slow to develop. Mental health and substance abuse service providers are not routinely trained to address the social factors that entrap victims in abusive relationships, which can result in mistakenly interpreting survival strategies as disorders, overlooking the advocacy needs (shelter, legal assistance, safety planning) of domestic violence victims, and not understanding the risks a psychiatric diagnosis can pose for custody battles with an abusive spouse. Additionally, court appointed psychological evaluations performed by practitioners who are not knowledgeable about domestic violence often work to the detriment of the victim rather than the perpetrator in custody hearings.

In response to the very real dangers the mental health system has posed to women who are being abused by a partner, the domestic violence advocacy community has been understandably reluctant to frame the psychological consequences of abuse in mental health terms. In addition, most domestic violence programs have limited resources to respond to women with acute mental health needs. And, given the pressing safety and advocacy needs of battered women, long-term recovery from trauma has not been the focus of domestic violence interventions.

The Domestic Violence and Mental Health Policy Initiative (DVMHPI) is currently engaged in addressing these and other concerns by facilitating a collaborative process to better understand and respond to the mental health needs of battered women. The initiative is designed to examine the barriers and gaps in service that impede optimal care, and to collectively generate strategies to improve both the advocacy and mental health system response to domestic violence both nationally and in Chicago.

PARTICIPATING PROGRAMS

The first step in this process was to conduct a thorough needs assessment with 15 participating programs. A list of Chicago-area domestic violence advocacy programs was generated and individual program directors were contacted by telephone. In the course of those conversations, many program directors remarked that other advocates in their program might contribute different and important perspectives on the issues central to the needs assessment. Accordingly, project staff arranged to visit each domestic violence program to meet with key advocates. These visits ranged in length from one to two hours and were conducted during late 1999 through early 2000. In most cases, the program director and multiple staff persons attended meetings; in a few cases only one or two program representatives participated.

Prior to the first visit, the DVMHPI generated a list of questions to serve as a guideline for discussion (see Appendix B). In most cases, programs were provided with the questions in advance. Program directors were told that the meetings would be informal and that the questions were designed to help structure the conversations.

Although not initially intended as focus groups, the questions developed by DVMHPI provided a consistent focus for discussion and generated both a rich body of cross-agency information and an important opportunity to begin a dialogue about these issues.

PRIMARY ISSUES FOR WOMEN IN DOMESTIC VIOLENCE PROGRAMS

Mental Health

All of the participating programs reported that considerable numbers of the women they serve experience mental health problems related to their experience of abuse. When asked how many women in their programs have identifiable mental health problems, estimates ranged from 30-90%. According to participants, the most prevalent mental health problem for the women in their programs is depression, cited by one advocate as “part and parcel” of abuse. Other mental health problems commonly seen include post-traumatic stress disorder, anxiety and panic disorder, and substance abuse. Additionally, some programs reported that they serve a small but noteworthy group of women with severe mental illness, including women who suffer from bi-polar disorder and schizophrenia. Finally, most programs reported that more than half of the women in their program have experienced multiple forms of trauma throughout their lives. One advocate, however, noted that an equally large proportion of clients in their program have *no* history of violence prior to the current abusive relationship.

Many participants were careful to distinguish between mental health problems that require psychological and/or psychiatric intervention and those that are normal responses to the experience of abuse and that lift when women are safe and have access to advocacy services. In many cases, women with mild depression or other minor mental health problems improve as a result of the support, safety, and advocacy available in domestic violence programs. Advocates reported that at least half of the depressed women they were seeing would benefit from “sensitive and appropriate mental health services.” A common theme was that loss, grief, anger, and trust issues stemming from or exacerbated by abuse should *not* be immediately interpreted as signs of mental illness. Many advocates reported that anger is a response that pervades women’s experience of abuse and that frequently does not emerge until women reach the safety of shelter. Programs struggle with where to draw the line, recognizing the importance of giving women an opportunity to work through their anger but also needing to maintain an environment that is emotionally safe for all women and children.

Substance Abuse

Programs reported that substance abuse is a considerable problem for their clients. Some programs estimate that as many as half of their clients have substance abuse problems. Due to the demands of maintaining a communal living arrangement, most programs make sobriety a requirement while women are in shelter. Yet many programs grapple with this requirement, recognizing that in many cases, substance abuse problems develop as women try to cope with ongoing abuse. Several

participants observed that women get overwhelmed when this coping mechanism is taken away.

Because of concerns about overly punitive responses, many programs do not immediately terminate clients who are found to be using alcohol or other drugs, but try to work with women and link them to appropriate substance abuse services. Most programs terminate shelter services only if use continues after efforts are made to ease the shift into abstinence. One program employs a full-time certified substance abuse counselor to assist women with addictions.

Children

Many participants talked about problems they observe among children in their programs. Several programs reported that they see children having a lot of emotional difficulties, including nightmares, bed-wetting, acting out physically and sexually toward other children, and overly responsible behavior. Another problem observed among children, especially boys, is abusive behavior toward the mother. Some participants attribute this to the fact that many children are not accustomed to seeing their mothers as authority figures. Another program remarked that they observe many girls going to great lengths to please others and to be liked, and that they believe these girls feel "at one with their mother."

For many women, witnessing these patterns of behavior is a factor in their decision to seek help from domestic violence programs, and an important issue for them is how to discipline their children. However, one program reported that children in their program exhibit very few emotional problems and those who require additional intervention are few and far between.

CURRENT PRACTICES AND SERVICES

Domestic Violence Counseling vs. Mental Health Services

Aside from one agency that provides only legal services, all of the participating programs provide domestic violence counseling. Broadly described, domestic violence counseling is grounded in the principles of advocacy and feminist theory and may include: education about abuse and the dynamics of domestic violence; validation and support; safety planning; and case management. It is distinct from mental health counseling, which is characterized by its intent to address mental health problems such as depression and anxiety. While a few of the programs do employ clinicians who are trained as mental health providers, most programs' counseling services are limited to domestic violence counseling.

Many programs reported that they would like to provide a variety of mental health services but are limited by lack of resources and funding. On the other hand, some of the programs do not provide mental health services for philosophical reasons, wanting to maintain programmatic focus on peer support rather than structured clinical services.

Serving Women and Children with Mental Health Needs

All of the participating programs reported a general willingness to work with women with mental health issues, and none use mental illness as a strictly exclusionary criterion. Most of the programs include questions about mental health, psychiatric hospitalization, and use of psychotropic medications in the intake interview. The majority of programs also include questions about substance abuse. Participants reported that many women are forthcoming with this information, but that others do not disclose for fear they will be denied services or reported to DCFS. Most programs will provide shelter and other services to women with mental health problems, provided they are stable and agree to adhere to treatment recommendations (including medication, when necessary). Most programs will also work with women with substance abuse issues, provided they are ready to attempt sobriety while they are in shelter.

Participating programs, shelters in particular, do find it taxing to accommodate women with mental health needs. Participants pointed to the stress of communal living as a factor that can precipitate or exacerbate mental health problems. Many shelter programs find that vulnerable women may become increasingly withdrawn, anxious, or paranoid while in shelter. On the other hand, one program identified departure from shelter as a common trigger for depression.

A number of programs reported that they are seeing increasing numbers of women with mental health problems. Participants cited various reasons for this, including poverty, welfare reform, and increasing awareness of domestic violence and advocacy resources.

As expected, domestic violence programs reported that they cannot accommodate women who are actively psychotic or who pose a risk to themselves or others. When sheltered women are in such severe distress, finding appropriate placement can be difficult. Some programs receive assistance from Thresholds' Mobile Assessment Unit (and, in emergencies, from local police) when working with women in the midst of a psychiatric crisis.

For reasons described in greater detail below, most programs reported that they are reluctant to refer women to the mental health system. Because of their misgivings, programs struggle with their own limited resources to assist women with marked mental health problems. Consequently, many advocates reported that they feel overwhelmed by cases that require intensive intervention. One participant described this as the struggle "to be all things to all people," since appropriate alternatives are too often unavailable.

In-House Mental Health Services

As previously mentioned, some participating programs offer various kinds of mental health services in-house. For example, one shelter has a licensed clinical social worker on staff who provides mental health counseling to individual women; this social worker also facilitates support groups for women in shelter. Additionally, some of the

non-shelter programs offer more in-depth counseling to women and can provide these services for a longer period of time. Specific types of arrangements for on-site mental health services are described below.

Beacon Therapeutic Services

Three of the participating programs are contracted with Beacon Therapeutic Services, which provides on-site mental health services to women in shelter. Their mobile mental health team is comprised of a psychiatrist, psychologists, and social workers. Beacon's services include assessment, psychological testing, psychotherapy, case management, and some medication, and they can continue to work with women after they have left shelter. Additionally, they facilitate anger management and parenting groups. Beacon's mental health team works with women in over twenty shelters in the Chicago area, the majority of which are not solely intended for battered women. Noteworthy from this perspective is Beacon's report that domestic violence is central issue for the overwhelming majority of homeless women in shelters.

Illinois Children's Therapy Project

Several programs have recently begun providing mental health services for children as part of the Illinois Children's Therapy Project of the Illinois Coalition against Domestic Violence (ICADV). Under this project, ICADV awards grants to programs, which in turn use the funds to pay for consultation, evaluation, and treatment for children with emotional problems. Participating programs are at liberty to choose the provider or providers with whom they wish to work. While the programs that provide these services are generally satisfied with the arrangements, two problems were cited. First, because the funding is limited, programs can only extend these services to children exhibiting more acute symptoms. Second, one program reported real difficulty finding appropriate and knowledgeable providers. One program that does *not* participate reported that they elected to not apply for funding for philosophical reason, wanting to avoid evolving into a structured clinical program.

Private Referrals

A handful of programs have negotiated referral relationships with individual mental health providers who work with women on a sliding scale or pro bono basis. In some cases providers see women on-site in the shelters; others see women in their private practices. Many programs report that they have long-standing relationships with these providers and a great deal of confidence in their ability to work safely and effectively with battered women. They are also cited as a resource for helping programs navigate the mental health system. Unfortunately, some programs are unable to locate providers who are willing to work with battered woman for a reduced fee.

REFERRALS TO THE MENTAL HEALTH SYSTEM

As previously noted, most of the participating programs work with sizable numbers of women who need mental health services above and beyond what is available in the domestic violence program or in the network of private practitioners described above.

In order to respond to those women, programs must navigate the very fragmented mental health system, which includes: hospitals, state-funded community mental health centers, private mental health and social service agencies, and private practitioners. The following paragraphs provide an overview of the range of settings to which programs refer clients in various stages of psychological distress.

Crisis Intervention

On occasion, programs (especially shelters) must respond to women in the midst of psychiatric crises. In these cases, programs generally refer women to local hospitals for psychiatric evaluation and inpatient hospitalization, if necessary. Many programs will have a staff member accompany the woman to the hospital, if feasible. Programs will also call 911 to request assistance from police officers or an ambulance when such assistance is needed. Programs named the following hospitals among their referrals: Christ, Hartgrove, Holy Cross, Jackson Park, Lakeshore, La Rabida (for children), Little Company of Mary, Ravenswood, St. Francis, St. Mary's, University of Chicago, and Weiss. Also named were state-run psychiatric hospitals: Chicago Read, Tinley Park, and Madden.

A few programs call on Thresholds Mobile Assessment Unit to assist in determining appropriate responses to women exhibiting signs of psychiatric distress. The Mobile Assessment Unit provides 24-hour, 7-days-a-week assessments and facilitates linkage with the least restrictive and most clinically appropriate service (they cannot arrange for alternate housing). Programs that work with Thresholds are quite satisfied with their services; however, some programs reported that they are out of Thresholds service area and therefore cannot depend on their assistance.

Evaluation and Treatment

Women with non-emergent mental health concerns are referred to a variety of outpatient mental health agencies. These referrals include: state-funded community mental health centers operated by the City of Chicago Department of Public Health; state-funded community mental health centers operated by not-for-profit entities, including those affiliated with hospital psychiatry departments; private, not-for-profit social service agencies and health clinics that provide mental health services; privately funded mental health agencies; private practitioners; and other agencies to which programs may refer if the client has need of specialized services.

Community Mental Health Centers

Included in the list of City-operated community mental health centers are the following sites: Pilsen-Little Village Mental Health Center, Back of the Yards Mental Health Center, and Greater Lawn Mental Health Center. Among the community mental health centers that are privately operated are: Metropolitan Family Services (91st street site), Community Counseling Centers of Chicago, Ravenswood Mental Health Center, Fillmore Center, Grand Prairie Services, Oak Park/River Forest Family Services, Proviso Family Services, and the mental health centers at Evanston and St. Francis hospitals in Evanston.

Social Service Agencies

Social service agencies and clinics to which women are referred for mental health services include: Ada McKinley Community Services, Association House, Casa Central, Asian Human Services, Chicago Health Outreach, and Indian Health Services.

Special Needs

Programs also refer women to specialized services under certain circumstances. For example, a number of programs refer women with severe and persistent mental illness to Thresholds, which offers a range of psychiatric rehabilitation services. Also, some programs refer women with a history of sexual assault to YWCA Women's Services.

Private Mental Health Agencies

Finally, domestic violence programs also refer women to mental health agencies that are privately run and funded. They include: the Center for Contextual Change, the Family Institute, and Woman Care.

CONCERNS ABOUT THE MENTAL HEALTH SYSTEM

Broadly speaking, domestic violence programs are concerned about the quality of care in the mental health system. Their concern can be described on two levels. On a practical level, programs reported that the mental health system is fragmented and difficult to access. On a philosophical level, programs perceive an alarming lack sensitivity to and understanding of domestic violence that is detrimental to the safety and well-being of battered women. While some programs reported positive experiences interfacing with the mental health system, others complained of substandard and inadequate care and pointed to discrepancies in quality along socioeconomic, race, and gender lines.

PRACTICAL

Referral

A primary problem cited by nearly all of the programs is how difficult it is to secure an appointment for women in mental health agencies, especially community mental health centers. One participant described it as a "convoluted process." A number of factors contribute to this problem. First, most programs reported very long delays between the time a woman is referred and when she is finally seen for initial evaluation. Reports of the waiting time ranged from two to eight weeks. This lag time creates real challenges for shelters that can only accommodate women for a few months.

One program reported that waiting time is not a problem for them. However, this program is one that has a contract with Beacon, has private providers who come to the shelter to work with women, and does not make many referrals to outside agencies for mental health services. Another program finds they can usually minimize the delay by making numerous phone calls on their clients' behalf. One program

reported that even though they are aware of “DV sensitive” clinicians within a particular mental health agency, they cannot be sure that those clinicians will actually see their client.

Another problem that arises in the referral process (and is related to issues discussed below under Philosophical Issues) is a perceived unwillingness on the part of mental health agency staff to take referrals from advocates. Many participants reported experiences with mental health providers who did not recognize advocacy as a legitimate area of expertise and who were unresponsive or unhelpful if the referring advocate was not able to converse in clinical terms.

Treatment Criteria

Participants also named confusing treatment criteria as another obstacle to helping women access the mental health system. Some programs reported that community mental health centers will only work with women following psychiatric hospitalization. (This may have to do with the fact that some community mental health centers are restricted by their funding to provide services only to women with severe mental illness.) Programs also complained that rigid catchment areas pose an obstacle for continuing care when a woman leaves shelter for another residence. Participants also reported that the psycho-legal issues surrounding commitment are confusing and hinder their efforts to advocate for battered women in the mental health system.

Affordability

Scant availability of affordable services is an area of enormous concern for domestic violence programs. Although most programs are aware of agencies and providers who will work on a sliding fee scale (some as low as zero), the consensus is that most services are unaffordable. For example, one program explained that women who receive public benefits are technically considered to have an income and therefore do not qualify for free services; yet, the sliding scale fee offered is prohibitively high. One program reported they invest much effort in negotiating affordable fees for their clients. The problem is complicated by managed care and insurance issues. Some programs report that women cannot qualify for sliding scale fees if they have mental health benefits, but many women cannot use these benefits if they are covered under their abusive partner's policy. Or, many women cannot afford the co-payment required by their plan. Furthermore, women who can use their mental health benefits to cover services encounter difficulty locating covered providers, and their benefits may not be adequate for the optimum course of treatment. Finally, other potentially beneficial services are available *only* to uninsured women.

Additionally, some programs observed that even when the costs of mental health services are manageable, women frequently cannot afford prescribed medications. Consequently, some women do not take their medication, or do not take the drug according to instructions in order to stretch their supply, thus minimizing or diminishing entirely the drug's therapeutic effect.

Cultural Barriers

Some programs reported that they are troubled by the shortage of multi-lingual mental health providers. Participants report that while some mental health agencies may employ bi-lingual staff persons, it is still enormously difficult to arrange for a timely evaluation in a woman's native language. This is especially crucial for battered immigrant women who, in the opinion of one participant, have more at stake.

Referrals from the Mental Health System

Participating programs also interface with the mental health system when mental health providers refer women to advocacy programs. Participants have had mixed experiences. One agency reported that mental health providers frequently "dump" women in shelter, even in cases where domestic violence is not an issue or when the woman may require more structured support and psychiatric care. Once such women are in the shelter, their cases become especially burdensome for program staff, who must then locate appropriate placements. Additionally, one program reported that the discharge planners from inpatient psychiatric units are not always forthcoming with important details about the severity of women's mental health problems, also creating additional burdens for staff and for the women themselves when they reach the shelter. It was indicated that the Chicago Department of Human Services was responsible for most of the inappropriate referrals. This was attributed to CDHS workers struggling to find shelter for women who had not other alternatives. Most programs, though, report that the majority of the referrals they get from the mental health system are appropriate.

PHILOSOPHICAL

A second set of concerns about the mental health system's response to battered women stems from advocates' experience of the system's failure to recognize and respond to the social conditions that condone and perpetuate abuse. The range of theoretical models in which clinicians are trained, and through which they filter information, explain symptoms, and prescribe treatment often fail to address the complexity of domestic violence. Traditional pathology-in-patient models, which locate the crux of the problem within the woman, too often lead even well-meaning clinicians to pathologize battered women by interpreting coping mechanisms and survival strategies as psychiatric disorders, to provide interventions that may be inappropriate or unsafe (e.g. couples' therapy), to inadvertently collude with batterers who rationalize and deny their abusive behavior, to undermine women's efforts to seek help by focusing on what how they should change, and to devalue or dismiss the contributions of advocates to women's safety and well-being.

Diagnosis

Participants are sensitive to the fact that most mental health providers and agencies operate in a system that requires consumers to be given a DSM diagnosis. Unfortunately, because DSM diagnoses fail to capture the social underpinnings of abuse, participants have misgivings about this practice. Many participants view the

emphasis on diagnosis as an expression of the system's tendency to pathologize battered women. Psychiatric diagnoses create special risks to battered women, since many advocates report having seen diagnoses used against women in court. Participants reported that being "diagnosed" confirms batterers' assertions that the victim is crazy, and further undermines women's resilience. Most advocates are deeply troubled when mental health providers fail to appreciate these risks

Over-medication

Many participants have qualms about what they consider too-liberal prescription of psychotropic medications for battered women. For some advocates, this is another expression of the system's failure to address domestic violence at its roots. While many advocates testified to the benefits that medication provides to some battered women, they are concerned that too frequently it is not offered in conjunction with other important services. Additionally, some programs reported that, like a DSM diagnosis, psychotropic medication may undermine a woman's credibility in court. Finally, one participant reported that many women in recovery from addiction do not want to take medication because they consider it a relapse.

Couples Counseling

Several programs reported that they frequently encounter mental health providers (particularly those who take a family systems approach) who recommend and provide couples counseling. In many cases, this occurs despite the fact that advocates have discussed the dangers of couples' therapy with them and asked them to reconsider this practice. For example, one advocacy program provided extensive training on domestic violence to a large social service agency, describing the jeopardy conjoint therapy creates for battered women. Despite these efforts, that agency has continued to provide couples counseling to women and their abusive partners.

Batterers' Influence in the Mental Health System

A few of the participating programs expressed alarm over incidents in which they have seen batterers use the mental health system as an instrument of control over their partners. One program has worked with non-English speaking women whose partners have given false reports to mental health providers in order to have the women committed. This concern is echoed more subtly in advocates' concerns about the standard practice in emergency psychiatric settings of obtaining collateral information from women's partners. Without an awareness of the dynamics of domestic violence and without any mechanism for screening or detection, advocates are concerned that this necessarily leads to collusion with the batterer. According to one participant, the result is that women frequently are discharged from inpatient care in worse condition than when they were admitted.

Devaluation of Advocacy

Finally, many participants reported feeling that the importance of advocacy work is largely unrecognized by mental health professionals. Some advocates believe that

they are not taken seriously because of a lack of credentials and the grassroots nature of advocacy work.

OTHER BARRIERS

Beyond the practical and philosophical concerns described above, participants identified other barriers for battered women in need of mental health services.

Stigma

The most frequently cited barrier is the stigma associated with mental illness. Almost all programs reported that women resist referrals to mental health services because they fear the referral means that they are mentally ill. Advocates cited numerous influences contributing to the stigma of having mental health problems, including families of origin, religious communities, culturally and/or ethnically grounded notions about mental health, and popular misconceptions about mental illness. One program reported that stigma is especially a problem in the African American community. Another program, one that serves a largely Asian population, explained that in Asian culture, mental health services are seen as a Western invention and that the need for such services is an indicator of personal failure or family dysfunction.

One participant reported that the attitude of respect and concern that permeates advocacy work is an effective tool for minimizing the stigma associated with mental health services. Another participant suggested that culturally sensitive services and outreach on the part of the mental health system would also lessen the stigma and enhance women's willingness to seek help there. Finally, one program reported that many of the women they work with resist services when they see how sick other patients are.

Department of Children and Family Services

All of the participating programs cited the Department of Children and Family Services (DCFS) as a force that complicates their work with battered women. Many women are reticent to fully disclose mental health or substance abuse problems for fear of DCFS involvement or other punitive interventions. Many advocates reflected that this fear is well founded, and rooted in the agency's failure to integrate appropriate responses to domestic violence into their service plans. One program remarked that battered women "get lost in the system" when DCFS is involved. Additionally, advocates reported that DCFS typically sets insurmountable service goals for women and that their cases get dragged out, a fact which one advocate believes contributes to depression for some women. Some programs reported that mental health issues are used against women by DCFS, and that if the mother has psychiatric problems, chances are high that she will lose custody.

Programs also voiced concern that the services required by DCFS are often contraindicated. For example, the agency refers many women to couples counseling in addition to domestic violence services. Moreover, participants reported that DCFS can be very victim blaming. One participant stated that DCFS typically tells women

that if they return to the abusive relationship they will lose custody of their children. Meanwhile, DCFS does not provide the support necessary for women to leave abusive relationships.

Legal Issues

Many advocates reported that mental health issues are also used against women in court, and that certain court orders like psychiatric evaluations and mediation can have disastrous consequences for battered women. Most of the programs reported that their clients frequently get into very difficult custody battles with their abusive partners, and that mental health issues are frequently used to discredit women. Many participants reported that court ordered psychiatric evaluations are usually performed by professionals with little or no understanding of domestic violence, and that many women are afraid to be forthcoming in those evaluations for fear what they say will be used against them. As a result, the woman usually comes off looking worse than the batterer. Additionally, good court evaluations from a knowledgeable and sensitive evaluator who is willing to appear in court are prohibitively expensive. Finally, many participants objected to the courts' persistence in recommending mediation, described by one advocate as a waste of time and money that often increases danger for women.

RELATED CONCERNS

Vicarious Traumatization and Burnout

Another key issue that was raised in the discussions had to do with vicarious traumatization and burnout among domestic violence program staff. Participants reported that the ongoing "crisis climate" of domestic violence programs can eventually overwhelm advocates; one participant commented that she has seen skilled and compassionate advocates "fall apart." For advocates who are survivors of abuse themselves, working closely with other survivors around abuse issues can be re-traumatizing. Another factor contributing to burnout among domestic violence advocates is the fact that most programs are under-resourced for the scope and volume of the work they do. In the words of one participant, their sense of obligation to "take all comers" contributes to staff feeling overwhelmed, as does the typically low salary for domestic violence advocates.

Preventing burnout and vicarious traumatization (or, in some cases, re-traumatization) is a challenge for all of the programs. Many programs use one-on-one supervision to help advocates deal with these issues; other programs cite group supervision and staff meetings as a forum for coping with the stressful work setting. Many advocates reported the availability of informal supports, such as compassionate supervisors, as a sustaining factor. One program reported that they try to make sure that job candidates have been out of abusive relationships for at least two years and have done some work around their abuse before they are hired. Other programs remarked that advocates who have *not* sorted through their own experience tend to leave quickly. Most of the programs identified this as an issue that they are especially eager to see addressed by the DVMHPI.

Spirituality and the Role of the Clergy

Many participants reflected on the importance of spirituality and faith commitments among the women they serve. One of the programs has begun offering spirituality groups as a complement to traditional support groups, and another reported that it intends to do so in the near future. The programs that incorporate spirituality into their services find that many women respond well to it. One advocate remarked that it can be helpful for women to believe in something bigger than themselves, and that faith can be an agent of change in that it alleviates women's fears of being alone. However, an advocate from another program remarked that some women focus on God's role in their life to the exclusion of being able to recognize and appreciate their own initiative and strength.

Most programs remain concerned by the role pastoral counseling plays in keeping women in abusive relationships. Several advocates noted that very religious women are more inclined to seek help from a pastor, priest, or rabbi than from a mental health professional or domestic violence advocate, and that many women consider other types of counseling to be a betrayal of their faith. This tendency is disquieting for advocates who find, in general, that even well meaning pastoral counseling can have a detrimental effect on women's well-being and safety. For example, one program that has done a great deal of outreach and training with spiritual leaders finds that while their effort has led to an increase in referrals to their program, many of the clergy's attempts at intervention have been destructive. On the other hand, one program voiced concern that many mental health providers are dismissive of women's faith commitments, creating yet another obstacle for women who are in need of mental health services.

Grassroots Movement vs. Professionalization

Another key issue that was raised in the discussions centered on the increasing professionalization of domestic violence program staff. Some programs have hired staff with clinical degrees (usually MSWs) to provide onsite assessment and counseling for women and, in some cases, children as well. Some have hired substance abuse counselors to work with clients but not therapist/clinicians. Others have chosen not to follow that route, in part, out of a commitment to maintaining a grassroots approach to working with battered women and their children. They have, however, established relationships with trusted clinicians who assist in providing those services and training staff. Programs that do provide clinically trained counselors, however, still focus counseling efforts at addressing domestic violence related issues and do not provide treatment for other mental health problems. Even in those agencies, women are assessed and referred to other agencies or clinicians in the community.

As mentioned above, a number of programs expressed concern about the lack of respect on the part of mental health professionals for domestic violence advocates

when they are trying to assist women in accessing services or helping them negotiate the mental health system. Several noted that when a clinician /social worker did the interfacing rather than an advocate they were taken more seriously. For some programs this created a difficult dilemma: what seemed most helpful for women who did need mental health services also supported a professional hierarchy that was disempowering to advocates and ultimately to battered women.

Additional comments included: concerns that counselors working with children in shelters and non-residential programs be knowledgeable about child development and provide more clinically sophisticated interventions than art therapy; importance of having clinically trained and emotionally mature staff in place to assess mental health needs, address them as part of domestic violence counseling when appropriate and refer out when beyond counselors ability; need for clinically trained staff to address group dynamics in shelters and work with staff to prevent burnout/vicarious traumatization.

This is a critical issue we hope to address in the process of working with advocacy community: How do we provide optimal services for battered women and their children yet still maintain a feminist empowerment approach? How do we balance the importance of both clinically informed counseling and peer support? How do we address the often complex sequelae of trauma, the coexisting mental health and substance abuse problems facing some battered women and do so in a way that is truly empowering, does not create professional hierarchies among staff or between staff and the women utilizing our services? Are there models that incorporate the best of both perspectives?

Cultural Issues

A number of culturally specific issues also arose during these discussions. One involved the issue of stigma related to acknowledging any mental health issues, including depression, among African-American, Latino and Asian-American women. Cultural barriers included the need to be strong and tough – any mental health problem was seen as a sign of weakness - (particularly for African-American women); shame that would be brought to the family, particularly for Asian-American women; and concerns about DCFS taking custody for women who had any mental health diagnosis – this was true for low-income women of color from any ethnic background.

One program voiced particular concern about the growing number of women who were being committed by their husbands who were able to manipulate the health and mental health systems against their wives. They spoke about women who came to the US for arranged marriages – women who often did not speak English and had no family here to marry men who were well established with large family networks. Not only were they almost completely isolated, they were often unable to speak for themselves. Even if an abused woman wants to return to her family she is often unable to do so. The cultural pressure to remain married, to not bring stigma on the family (e.g. reducing a sister's chance of getting married) and the collusion of her in-

laws with the abuser further increase her level of entrapment. If a woman is committed and declared mentally incompetent, her husband is then able to import another bride and reduce his first to the level of servant. A number of programs were disturbed by the language barriers facing women trying to access mental health services - women who were not in positions to speak for themselves.

Addressing Critical Issues

Over the years some degree of tension has emerged as domestic violence programs with limited resources struggle to provide high quality services to meet the needs of battered women within a grassroots feminist empowerment framework. Increasing recognition of the large number of women who are struggling with the mental health and substance abuse sequelae of domestic violence (and for many women, a lifetime history of abuse) has put programs in the position of either not being able to meet those needs directly or having to hire clinically trained staff to meet some of those needs in-house.

How individual domestic violence programs approach these issues appears related to some degree to the particular background/training of executive directors and their philosophical perspectives. For example, executive directors with substance abuse backgrounds have that aspect of their program more fully developed. Those with MSWs are more likely to hire clinical staff. Those with a more grass-roots perspective tend to refer women with mental health problems to other agencies and providers. All of the programs we spoke with, however, are quite sophisticated about recognizing the prevalence of mental health issues and the importance of finding empowering, non-pathologizing ways to address them.

DVMHPI's intention is to facilitate discussion about these issues in ways that will be beneficial to all participating agencies and constituencies. This may mean developing several different approaches that we can all learn from or developing a consensus model that is implemented in a range of different programs. What is clear is there must be a way to assess and respond to women's mental health needs and to destigmatize the psychological sequelae of trauma. This raises the question of whether providing mental health services in-house offers greater assurance that clinicians will understand domestic violence issues or if it is more important to cultivate ongoing working relationships with a range of mental health providers. Given the range of options and resources, both will probably be important.

INITIAL SUGGESTIONS

During the meetings, participants were given an opportunity to comment on what kinds of changes and services are needed to ensure that battered women's mental health needs are met. Programs reported that they want simple and straightforward access to affordable mental health services for their clients, and that they want those services to be safe and empowering for women. Specific suggestions fall into the following broad categories: service access and availability, training, communication and consensus building, and activism.

Service Access and Availability

Most programs agreed that easier access to mental health services would benefit their clients with mental health needs. For some participants, this would ideally be achieved through linkage agreements, consultation arrangements, and collaborative relationships with local mental health providers and agencies. Other participants would like to make mental health services available within the domestic violence program itself. One suggestion was that some protocol or standards be developed for shelters to use when working with women with mental health needs. One participant also suggested making advocacy services available in mental health settings. Additionally, most programs are resolute that mental health services should be available without the requirement of a DSM diagnosis.

Training

Domestic violence programs want to know that they are referring women to services that are safe and empowering. To this end, programs strongly emphasized the need for domestic violence training for mental health providers, training that will facilitate a recognition of the scope and social context of abuse, as well as highlight the multiple ramifications battered women face when they interface with the mental health system. One participant reported that domestic violence training is a requirement for licensure for mental health providers in California, and that perhaps similar requirements should be made in Illinois.

Most programs stressed the importance of training mental health providers currently in practice; many participants also identified the crucial need for domestic violence to be integrated into the training curriculums for schools of medicine/psychiatry, psychology, social work, and other mental health professions, as well as in law schools and court education programs.

Some participants also suggested that advocates receive training on mental health issues and on the mental health service delivery system. Specific topics of interest included: signs and symptoms of mental illness; suicide assessment; substance abuse issues; how to access the mental health system; and psychiatric terminology.

Communication and Consensus Building

Some participants commented that domestic violence advocates and programs must communicate with each other about mental health issues. While there is consensus among programs that the mental health needs of battered women and their children should be addressed, there is less agreement about how specifically to specifically improve the response. One participant noted that the advocacy community has lost some of its ability to work as a team; for real progress to be made in the area of mental health, the advocacy community must share a common set of principles and goals that can accommodate the differing views and foci of individual programs. This is a vital task of the DVMHPI and we see our role as facilitating communication and consensus building between agencies and sectors.

Activism

Finally, participants emphasized the need for the mental health providers and policymakers to become more active in advocating for affordable, culturally competent, comprehensive services for *all* consumers of mental health services. Additionally, participants stressed that effort must be made to fight the stigma that prevents people from seeking needed services. One participant suggested that the mental health system would be far more effective were it to adopt more consumer-centered, healing-oriented approaches to service delivery.

Conclusion

Despite these concerns, the majority of advocates we spoke with are eager, albeit somewhat cautious, to begin working with mental health providers to address the needs of the women and children they serve. Advocates also expressed considerable interest in obtaining training for their staff on trauma-related mental health issues, on learning to identify mental health problems, and on communicating more effectively with mental health providers. In addition, advocates hope to gain some concrete resources for women in their programs, such as educational materials about the effects of violence on themselves and on their children, as well as information to help staff deal with their own vicarious traumatization. Clearly, there is much work to be done to build collaboration, to develop models that bridge the philosophical and service delivery gaps described above and to promote healing, help women rebuild their lives and ultimately prevent domestic violence and its traumatic sequelae.

FOLLOW-UP SURVEYS

Approximately one year after these discussions were completed, project staff sent out short surveys to all the participating agencies in order to fill in some gaps and to establish baseline data for our ongoing evaluation (see APPENDIX B for survey questions and results). For the most part, the information gathered by the surveys supported the conclusions in this report. There does appear to be a discrepancy regarding the employment of mental health service providers and the provision of such services at domestic violence agencies, discussed below.

Originally, most domestic violence programs reported that they did not employ clinicians who were trained as mental health providers and that they did not provide mental health counseling. Even those agencies that did have clinicians on staff focused on domestic violence issues and not on other mental health problems. However, the surveys indicated that all programs “employ trained mental health providers” and that 93% of them “provide mental health services and domestic violence counseling.”

There are two possible explanations for this discrepancy. One explanation is that the staff who filled out the surveys were not the same as those who participated in the early conversations. Perhaps the survey respondents interpreted the questions about mental health service providers slightly differently from how they were intended. They may have included providers the agency was contracted with, such as those from Beacon Therapeutic Services, as trained mental health providers employed by their agency. Another plausible explanation is that the domestic violence agencies hired mental health service providers during the year between the two phases of information gathering, as a result of their involvement with the Domestic Violence and Mental Health Policy Initiative, thus dramatically increasing the amount of mental health services they provide.

In addition, during the earlier conversations held with domestic violence program staff, only one agency reported that it employed “a full-time certified substance abuse counselor,” but 47% reported having a “substance abuse specialist on staff” in the surveys. The explanation for these seemingly contradictory statements appears to lie in the wording. While 47% employ a substance abuse specialist, that person may not be a *certified* substance abuse counselor and may not work *full-time*.

APPENDIX A

DISCUSSION QUESTIONS FOR DOMESTIC VIOLENCE PROGRAMS

1. What services does your program provide?
 - Shelter
 - Legal advocacy
 - Hotline
 - Counseling/Mental health services
 - Case Management
 - Substance abuse services
 - Counseling/Mental health services for children
 - Other

2. If counseling services are provided:
 - a) Who provides them (level and type of training)?
 - b) Any particular theoretical orientation?
 - c) Length, frequency, and average number of sessions?
 - d) Individual or group?
 - e) Do counselors receive supervision?
 - f) If so, from whom?

3. If counseling services are not provided:
 - a) Do you find there is a resistance to acknowledging or responding to mental health problems?
 - b) Are clients screened or assessed for mental health problems and/or substance abuse issues?
 - c) Does your agency have a referral network for mental health and substance abuse services?

4. If your agency makes referrals to outside mental health or substance abuse providers, where do you refer?
 - Community mental health centers
 - Psychiatry departments
 - Social service agencies with mental health components
 - Providers in private practice
 - Other

5. What has your agency's experience with mental health providers/system been like?
 - a) Positive experiences
Describe
 - b) Negative experiences
Describe

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- c) Staff perception of impact on clients
6. What types of mental health problems/substance abuse issues is your agency seeing?
 7. What are the major mental health/substance abuse concerns facing the women you serve?
 8. What do the women you serve find most problematic regarding their mental health needs?
 - a) Symptoms
 - b) Confusion about why they feel the way they do
 - c) Stigma
 - d) Lack of access to services
 - e) Lack of financial resources to receive outside counseling
 - f) Negative experiences with the mental health system
 - g) Control of mental health service utilization by abuser
 - h) Other
 9. What do they find most helpful?
 10. Does your agency incorporate cultural or non-traditional approaches to healing into its work?
 11. What types of mental health problems/substance abuse issues are particularly problematic for your agency?
 12. In what ways have clients' mental health/substance abuse problems and/or involvement with the mental health system played a role in legal proceedings (orders of protection, custody battles, divorce proceedings, etc.)?
 13. What changes/improvements in the mental health system do you think would be beneficial to battered women and their children?
 14. What types of changes in the legal system (regarding mental health/substance abuse and domestic violence) would you like to see?
 15. What types of resources or technical assistance would your agency value in attempting to address mental health/substance abuse issues in-house?
 16. What do you see as the opportunities for and barriers to collaboration with mental health providers and agencies?
 17. What kinds of models would you envision for bridging these gaps in services for battered women and their children?

APPENDIX B

DOMESTIC VIOLENCE SURVEY AND RESULTS

“Results” indicates the number of agencies that selected each answer

1. Please estimate how many women in your program have identifiable mental health problems:

	very few	less than half	about half	more than half	most	don't know
Results:	1	4	5	4	1	0
Total: 15						

2. Of women with identifiable mental health problems, for how many do you believe the mental health issues are related to partner abuse (as opposed to situations where women have pre-existing mental illnesses that are exacerbated by partner abuse):

	very few	less than half	about half	more than half	most	don't know
Results:	2	3	8	1	1	0
Total: 15						

Domestic violence advocates have reported numerous issues and concerns common to many survivors of domestic violence. Please consider the following statements and indicate to what extent you agree or disagree by circling the response that best reflects your opinion:

3. Loss, grief, anger, and trust issues stemming from or exacerbated by abuse are common, but should not immediately be interpreted as signs of mental illness.

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly
Results:	14	1	0	0
Total: 15				

4. Anger is a common response to abuse that frequently does not emerge until women reach the safety of shelter.

Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly
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Results:	7	7	1	0
Total: 15				

5. Among women in your program who are depressed, please estimate:

5a. How many get better during their stay in shelter (or during their time as a client):

	very few	less than half	about half	more than half	most	don't know
Results:	1	2	2	5	4	0
Total: 14						

5b. How many need or would benefit from sensitive and appropriate mental health services (such as those provided by a counselor, psychologist, or psychiatrist):

	very few	less than half	about half	more than half	most	don't know
Results:	0	0	2	6	6	0
Total: 14						

6. Please estimate the proportion of women in your program for whom substance abuse is a problem:

	very few	less than half	about half	more than half	most	don't know
Results:	5	5	3	2	0	0
Total: 15						

7. Is sobriety a requirement for women in your program? YES NO

Results:	9	6
Total: 15		

Please read the following statements and indicate to what extent you agree or disagree:

8. Many battered women develop substance abuse problems as a way of coping with the violence to which they are subjected.

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly
Results:	9	5	0	0
Total: 14				

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9. Many women with substance abuse problems become overwhelmed when this coping mechanism (substance abuse) is taken away.

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly
Results:	5	7	2	0
Total: 14				

10. Many women are coerced into using or continuing to use drugs or alcohol by an abusive partner.

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly
Results:	5	9	0	0
Total: 14				

11. How does your program respond to women who are found to be using alcohol or other drugs while living in shelter/receiving services?

Results:	
11	Refer them for substance abuse evaluation/services.
10	Make substance abuse evaluation/services a condition for staying in shelter (or continuing to receive services).
2	Terminate shelter/services
3	Other

12. Does your program have a substance abuse specialist on staff? YES NO

Results:	7	8
Total: 15		

13. Please estimate how many children in your program have emotional difficulties that require mental health intervention:

	very few	less than half	about half	more than half	most	don't know
Results:	5	3	3	2	1	1
Total: 15						

14. Many advocates report that they see a significant number of children display abusive behavior towards their mothers. Please circle the response that best reflects how often you have observed this among the children in your program.

often sometimes rarely never

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Results:	4	9	1	0
Total: 15				

15. Does your program employ counselors who are trained mental health providers (i.e., MSWs, LCPCs, psychologists, etc)?

YES NO

Results:	15	0
Total: 15		

15a. If yes, do they provide mental health services (i.e., address mental health problems such as depression and anxiety)?

YES NO

Results:	14	1
Total: 15		

15b. If yes, do they provide domestic violence counseling (i.e., education about abuse and the dynamics of domestic violence; validation and support; safety planning; and case management)?

YES NO

Results:	14	0
Total: 14		

16. Is your program philosophically *opposed* to providing clinical mental health services?

YES NO

Results:	0	13
Total: 13		

17. Is your program willing to work with women with mental health issues provided they are stable and able to adhere to treatment recommendations?

YES NO

Results:	14	0
Total: 14		

18. Is your program willing to work with women with substance abuse issues provided they are not using and are willing to adhere to sobriety requirements or treatment recommendations?

YES NO

Results:	14	1
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Total: 15

19. Many programs report that they are seeing a significant number of women with mental health issues. Is this true of your program? YES NO

Results: 14 1
Total: 15

19a. If yes, do you have enough resources to address them? YES NO

Results: 4 9
Total: 13

20. Does your program participate in the Illinois Children's Therapy Project of Illinois (administered by ICADV)? YES NO

Results: 3 12
Total: 15

21. Does your program have (an) established relationship(s) with mental health provider(s) in private practice? YES NO

Results: 6 8
Total: 14

22. Do you have concerns about the quality of care for battered women and their children in the mental health system? YES NO

Results: 15 0
Total: 15

23. Is the process of making a referral to a mental health provider or agency problematic for your program? YES NO

Results: 12 3
Total: 15

23a. If yes, why?

Results:

2 _____ Confusing
11 _____ Wait for appointment is too long
6 _____ DV staff have a hard time communicating with MH intake staff
6 _____ Confusing treatment criteria

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6 _____ Other

24. Do you think that accessing mental health services is difficult for battered women?

	YES	NO
Results:	15	0
Total: 15		

24a. If yes, why?

Results:		
13 _____	Services are unaffordable	
12 _____	Inadequate insurance coverage	
10 _____	Women can't use insurance benefits because of confidentiality or due to batterer's control	
12 _____	Cultural barriers	
14 _____	Stigma	
4 _____	Other	

25. Does your program receive referrals from mental health providers? YES NO

Results:	12	3
Total: 15		

25a. If yes, do you think that referring mental health providers have an understanding of what your program does? YES NO

Results:	5	5
Total: 10		

25b. If yes, do you think referring mental health providers acknowledge the importance of what your program does? YES NO

Results:	7	2
Total: 9		

26. Do you have philosophical concerns over the approach of the mental health system to domestic violence/battered women and their children? YES NO

Results:	15	0
Total: 15		

26a. If yes, why?

Results:

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- 12 _____ Emphasis on psychiatric/DSM diagnosis
- 9 _____ Emphasis on medication and primary intervention
- 12 _____ Couples counseling
- 13 _____ Disregard for or ignorance of safety issues
- 12 _____ Batterer's ability to control via the mental health system
- 10 _____ Devaluation of advocacy
- 4 _____ Other

27. Do you see other barriers for battered women who need to access the mental health system? YES NO

Results: 15 0
 Total: 15

27a. If yes, what are they?

- Results:
- 10 _____ DCFS involvement
 - 15 _____ Legal issues (divorce, custody hearings)
 - 5 _____ Other

28. In what ways does your program attempt to mitigate vicarious traumatization and burnout?

- Results:
- 14 _____ One-on-one supervision
 - 8 _____ Group supervision
 - 12 _____ Supportive work environment
 - 4 _____ Employee assistance program
 - 12 _____ Training
 - 3 _____ Other

29. Does your program offer spirituality groups or other services that approach issues from a spiritual perspective? YES NO

Results: 2 13
 Total: 15

30. Domestic violence programs have different philosophies regarding the professionalization of staff. Does your program employ professionally trained staff persons such as MSWs, MAs, LCPCs, or psychologists? YES NO

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Results:	15	0
Total: 15		

30a. If so, why?

Results:

15	Skills and training considered necessary
4	Funders require it
6	Individuals with advanced degrees/training are most qualified candidates

31. Does your program provide services to women who have been in lesbian battering relationships?

YES NO

Results:	14	1
Total: 15		