

CRITICAL COMPONENTS OF INCLUDING DOMESTIC VIOLENCE SAFETY & RESPONSE IN MENTAL HEALTH REFORM

Mental health reform is an important issue for those survivors of domestic violence and their children who are experiencing the traumatic effects of abuse. However, individuals who are experiencing domestic violence have unique needs with regard to how services are delivered and how privacy is maintained.

Research shows that women in mental health settings experience high rates of domestic violence. Across studies, 30% of women seen in outpatient settings, 33% of women in inpatient settings, and 60% of women in psychiatric emergency room settings reported experiencing domestic violence in their lifetime. (Warshaw, citing Jacobson (1989); Lipschitz, et. al (1996); Goodman, et. al (1995); Friedman (2007); Cluss, et. al (2010); Oram (2013)).¹ Because a large percentage of individuals who seek mental health services also have experiences of past or ongoing domestic violence, preparedness to respond to domestic violence is a critical part of a comprehensive mental health system.

Currently, however, most mental health providers are not equipped to respond to domestic violence. For example, a survey of state mental health departments conducted by the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) in partnership with The National Association of State Mental Health Program Directors (NASMHPD) found that less than half (45%) of state mental health departments stated that they were coordinating activities with state-level domestic violence organizations.²

Preparedness to respond to domestic violence in the context of behavioral health settings should be a baseline standard for the field. There are several components of such an approach:

- 1. Funding for Training & TA to Build Capacity:** Funding is needed to support training and technical assistance on domestic violence for the mental health field. Behavioral health agencies should receive (1) regular training for staff on identifying and responding to DV in behavioral health settings, as well as (2) ongoing support and consultation to develop

¹ For an updated summary of current research on this topic, see NCDVTMH's fact sheet, *Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness*, available here: http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf

² THE NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH (NCDVTMH), IN PARTNERSHIP WITH THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS (NASMHPD), SURVEY OF STATE MENTAL HEALTH ADMINISTRATORS: SUMMARY OF RESULTS (2014), <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/09/StateMHAdminFinalSubmitted4.29.141.pdf>.

comprehensive protocols for responding to domestic violence and to establish referral relationships with domestic violence programs and hotlines.

- 2. Investment in Long-Term Workforce Development:** Investment in the development of a workforce that is trained to respond to domestic violence is also critical. For example, this could be accomplished through incentivizing graduate mental health professional training programs to incorporate domestic violence coursework.
- 3. Encouraging Domestic Violence Preparedness at the Agency Level:** Ultimately, every mental health agency in the country should be fully prepared to identify and respond to domestic violence, foster robust relationships with local domestic violence programs for the purposes of referral and collaboration, and utilize documentation and record-keeping practices that minimize domestic violence-related safety risks. Of course, for already under-resourced behavioral health agencies, putting these interlocking components in place requires dedicated time and resources. Incentives and financial support are needed for behavioral health agencies to invest in the long-term process of adopting comprehensive agency-wide protocols for responding to domestic violence.
- 4. Encouraging Research on Trauma Treatment Designed to Meet the Unique Needs of Survivors of Domestic Violence:** DV survivors deserve access to a full range of advocacy and support services, including trauma-specific treatment. However, as NCDVTMH found in its 2013 literature review of existing trauma-specific treatment models for DV survivors, “While there are numerous interventions designed to reduce trauma-related mental health symptoms, most were originally developed to address events that have occurred in the past. Many domestic violence survivors are still under threat of ongoing abuse or stalking, which not only directly impacts their physical and psychological safety but impacts treatment options as well. Little has been known about the extent to which existing evidence-based trauma treatment modalities are applicable to, or require modification for, domestic violence survivors.”³ To fill this gap, investment is needed to support the development of trauma-specific treatment models that address the unique needs of domestic violence survivors.
- 5. Non-Involvement of Abusive Family Members Family:** The Health Insurance Portability & Accountability Act of 1996 (HIPAA) allows for mental health providers to involve family members in an individual’s mental health treatment when certain criteria are met.⁴ The involvement of supportive family members in an individual’s mental health

³ CAROLE WARSHAW, CRIS SULLIVAN & ECHO RIVERA, A SYSTEMATIC REVIEW OF TRAUMA-FOCUSED INTERVENTIONS FOR DOMESTIC VIOLENCE SURVIVORS (2013), http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH_EBPLitReview2013.pdf.

⁴ Statement of Deven McGraw, Center for Democracy and Technology, *Does HIPAA Help or Hinder Patient Care and Public Safety?* April 26, 2013.

care can be appropriate and helpful under some circumstances. However, for individuals whose family member(s) are perpetrating domestic violence or child abuse, their involvement creates unique risks. For safety reasons, including fear of retaliation, a survivor may not want their abusive partner to have access to their health or behavioral health information or personal information. In some cases, the fact that the survivor has sought help at all might put that survivor at risk of retaliation. The possibility of family involvement may cause survivors to delay seeking needed mental health services—or go entirely without services—for fear their sensitive information will be shared. For these reasons, increasing the involvement of family members in an individual’s treatment is not necessary and may be harmful. Additionally, mental health providers should be trained to assess for domestic violence and other forms of intrafamilial abuse prior to involving a family member in a patient’s care.

6. Protecting Survivors’ Privacy & Safe Keeping of Records: Increased use of Health Information Technology (HIT) promises important advances in coordination of patient care. At the same time, the right protections must be in place to ensure patient choice, safety, and privacy. Electronic Health Records (EHRs) present both exciting opportunities and potential dangers for survivors of domestic violence in particular. It is critically important that EHRs have the functionality to segment and protect sensitive mental health and domestic violence information, so that survivors can make choices to protect their safety. This could be accomplished through

- Requiring that EHRs include the functionality to segment and protect sensitive data (granularity) in order to be certified by ONC.

Additionally, the need for a robust informed consent process accompanying solicitation of patient consent to share records is critical given the modern era of EHRs. This could be accomplished through

- Requiring that providers use rigorous in-person or tablet-based informed consent procedures that allow patients to thoroughly assess the pros and con of sharing sensitive information and identify potential risks, including safety risks related to domestic violence;
- Providing funding for the development of such procedures, including developing user-friendly consent forms in multiple languages, with input from experts on sensitive information such as domestic violence data; and
- Providing funding for designated staff at behavioral health organizations to be trained and available to solicit genuinely informed consent from patients.

7. Recognizing Safety Risks Posed by Increased Use of Assisted Outpatient Treatment

(AOT): NCDVTMH agrees with the concerns and cautions that many others have raised about the use of assisted outpatient treatment (AOT).⁵ NCDVTMH believes that increased use of AOT will also create additional risks for survivors of domestic violence. In our work, we have learned that some abusive partners attempt to convince mental health providers that survivors are “crazy” in order to control survivors and undermine their credibility. Two national surveys conducted with the National Domestic Violence Hotline found that survivors of domestic violence routinely experience coercive tactics related to mental health and substance use, including deliberate attempts by abusers to control access to treatment and sabotage recovery, have their partners involuntarily committed to inpatient facilities, and then use these issues against survivors to undermine their credibility with authorities including law enforcement and the courts.⁶ Survivors who responded to the survey specifically told researchers that abusers attempted to convince police or doctors that they were mentally ill. For these reasons, we are concerned that increased use of AOT may provide additional opportunities for abusive partners to use these issues against survivors.

⁵ See, e.g., Mental Health America, Issue Statement 22: Involuntary Mental Health Treatment (<http://www.mentalhealthamerica.net/positions/involuntary-treatment>).

⁶ Carole Warshaw, Eleanor Lyon, Heather Phillips, Patricia J. Bland, Mikisha Hooper, MENTAL HEALTH AND SUBSTANCE USE COERCION SURVEY: REPORT FROM THE NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH AND THE NATIONAL DOMESTIC VIOLENCE HOTLINE (2014) http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf