

**Domestic Violence
& Mental Health
Collaboration Project**

**Needs & Strengths Assessment
Findings Report**

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○○○ Introduction

In October of 2007 the Domestic Violence and Mental Health Collaboration Project was awarded a three year grant from the Office on Violence Against Women, U.S. Department of Justice. The purpose of the grant is to create sustainable systems change for survivors of domestic violence who have disabilities and/or who are Deaf. The grant has two phases: planning and implementation. We are currently in the planning phase. The project partners have been working on strengthening relationships between our organizations and have jointly created a collaboration charter and have worked collectively to narrow the focus of our project. In February of 2009 we completed a needs and strengths assessment. The assessment was designed to collect data that would allow us to develop a well-informed and practical strategic plan. Our strategic plan will direct our work during the implementation phase of the grant and during the subsequent years.

The Domestic Violence & Mental Health Collaboration Project is comprised of representatives from local government, a county-wide domestic violence coalition, a community-based domestic violence organization, a community-based mental health organization, and two organizations that provide mental health, chemical dependency, and domestic violence services. The latter two organizations specialize in services for the Spanish-speaking immigrant community and the LGBT community respectively. The six project partners are:



The City of Seattle Human Services Department, Domestic Violence and Sexual Assault Prevention Division which works to keep all adults and children safe from domestic violence and sexual assault. The City of Seattle helps victims and survivors create safe and violence-free lives, and heal from the trauma of abuse or sexual assault. The City of Seattle is represented by their Senior Planning and Development Specialist.



Consejo Counseling and Referral Service which provides behavioral health, chemical dependency and domestic violence services to immigrants from Latin America who speak Spanish as their primary language. Consejo provides services across the state of Washington. Consejo is represented by staff from their domestic violence and mental health programs.



The King County Coalition Against Domestic Violence (KCCADV) which works to end domestic violence by facilitating collective action for social change. In county-

wide public policy and education efforts, the Coalition provides leadership on behalf of community-based victim service agencies and their allies. The Coalition strives to represent the diverse interests of victims and survivors of domestic violence. KCCADV is represented by their Executive Director and by the Project Coordinator.



New Beginnings (NB) which provides an array of services for battered women and their children including a 24-hour help line, advocacy-based counseling services, community-based support groups, emergency shelter, transitional housing and a social change program. New Beginnings also offers specialized services including a chemical dependency / domestic violence support group. New Beginnings is represented by their Executive Director and by their Program Director.

Proudly serving the LGBT Communities since 1969

SeattleCounselingService



Seattle Counseling Service (SCS), the first and oldest community mental health agency for lesbians, gay men, bisexuals, and transgender persons in the United States, which provides mental health care, chemical dependency treatment, domestic and sexual violence advocacy, and HIV/AIDS services. SCS also works with other King County providers to advocate on behalf of LGBT clients. SCS is represented by their Executive Director and by their Clinical Director.



Sound Mental Health (SMH) which provides a full continuum of recovery-oriented, community-based mental health and drug/alcohol treatment services including crisis intervention, rehabilitation, support, education, outpatient therapy, and residential programs. Nearly 11,000 clients throughout King County receive services each year. Sound Mental Health is represented by their Director of Counseling Services.

○○○ Vision, Mission and Focus

As part of our planning process we identified our project's vision, mission, and focus. Our needs and strengths assessment and our upcoming strategic planning process are guided by these.

Our Vision ~ We envision that domestic violence, mental health, chemical dependency and related organizations will be able to provide quality services to survivors of domestic violence who have disabilities in a manner that embraces their diversity.

Our Mission ~ The mission of the Domestic Violence and Mental Health Collaboration Project is to facilitate sustainable systems change within and among the participating organizations to better meet the mental health, safety and self-determination needs of survivors of domestic violence who have been traumatized or whose existing mental health problems have been exacerbated by domestic violence. The participating organizations will strive to make services more accessible, holistic, and integrated, to work more collaboratively together, and to effectively utilize reciprocal consultation.

Our Focus ~ Since our partner organizations all provide either domestic violence or mental health services, or both, and since we have identified a significant need for service improvements and internal changes related to survivors with mental health care needs, we decided to focus our efforts on creating change for survivors of domestic violence who:

have a disabling mental health problem as a result of trauma or whose existing mental health problems¹ have been exacerbated by domestic violence.

AND

are accessing services at Consejo Counseling and Referral Service, New Beginnings, Seattle Counseling Service or Sound Mental Health.²

We recognize that these survivors will include individuals with a wide range of additional disabilities.

¹ When we refer to "mental health problems" we are including struggles with chemical dependency.

² Please note: The City of Seattle and KCCADV do not offer direct service.

○○○ Goals

The Domestic Violence and Mental Health Collaboration Project had five primary goals for our needs and strengths assessment. The first two goals focused on what we hoped to learn from domestic violence survivors. The last three goals focused on what we hoped to learn from service providers. Working on these goals enabled us to obtain the information necessary to develop a well-informed, highly useful strategic plan. The strategic plan will guide us in improving services for survivors of domestic violence with mental health concerns and in strengthening collaborative relationships.

1. Learn from domestic violence survivors with mental health concerns:

- A. What is working well for them regarding services at partner agencies including:
 - the accessibility of services
 - the quality and responsiveness of services, and
 - the cultural competency of services

- B. What gaps and barriers exist for them concerning services at partner agencies including:
 - the accessibility of services
 - the quality and responsiveness of services, and
 - the cultural competency of services

2. Learn from partner organizations:

- A. What contributes to agencies' ability to provide quality services to domestic violence survivors with mental health concerns?

- B. Where are there barriers to the ability of agencies to provide quality services to domestic violence survivors with mental health concerns?

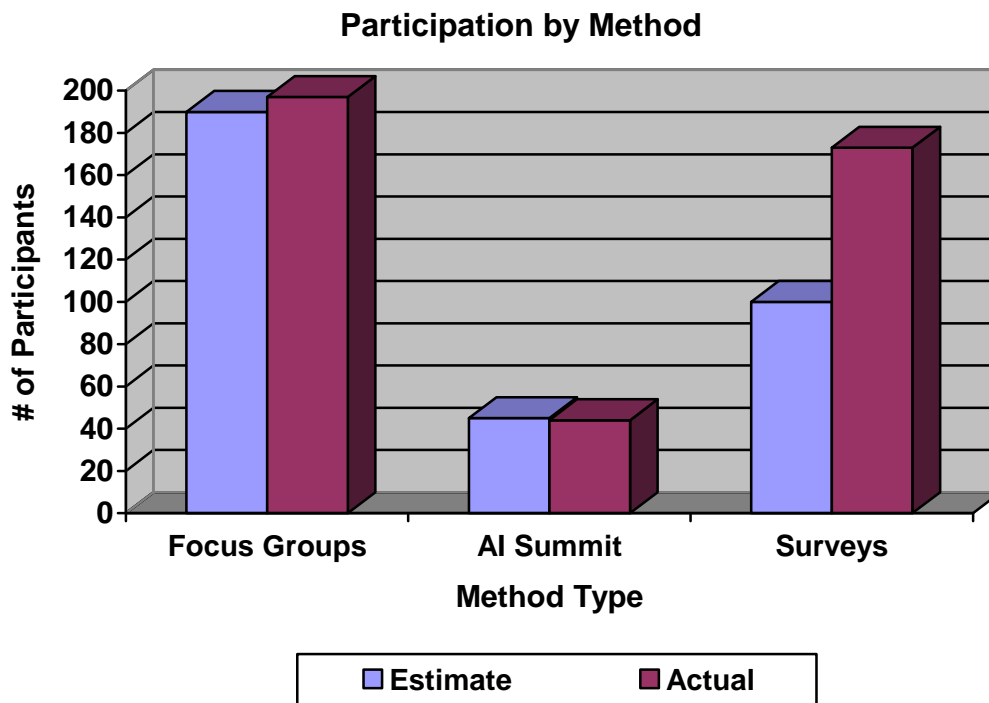
- C. What opportunities exist for change in our organizations?

○○○ Overview of Methods

We utilized a combination of data collection methods including focus groups, an Appreciative Inquiry Summit, and online surveys. Participants included board members and management, as well as people providing and receiving domestic violence, mental health, and chemical dependency services. It should be noted that service recipients who participated were asked to participate based on the location and type of services they were receiving (e.g. mental health services at Sound Mental Health) and not on the basis of identifying as *both* a survivor of domestic violence *and* someone with mental health or chemical dependency concerns. While participants fit into at least one of these categories, they did not necessarily fit into both. We believed that they would have much to contribute to the process whether they fit both categories or just one. Not surprisingly, many participants did share that they were struggling with both issues.





197 people participated in our focus groups, 44 people participated in our Appreciative Inquiry Summit, and 173 people responded to our online surveys. This gave us a total of 414 units of input with each survey response, summit participant, and focus group participant equaling one unit of input. However, this is not an unduplicated count. Some service providers participated in two or even all three data collection methods.

Our estimates for the number of focus group participants and summit participants were right on target. We underestimated the number of people who would respond to our online surveys. We appreciate that we had such a great response rate to our surveys. The chart below compares our estimates for participation to our actual participation levels.



○○○ Focus Groups

We conducted 22 focus groups with 197 participants (102 service providers and 95 service recipients) to learn what they think is working well and what they think needs to be improved regarding services for survivors of domestic violence with mental health or substance use concerns. Participants attended focus groups at the same organization where they provide or receive services. The table below illustrates who attended each of the focus groups.

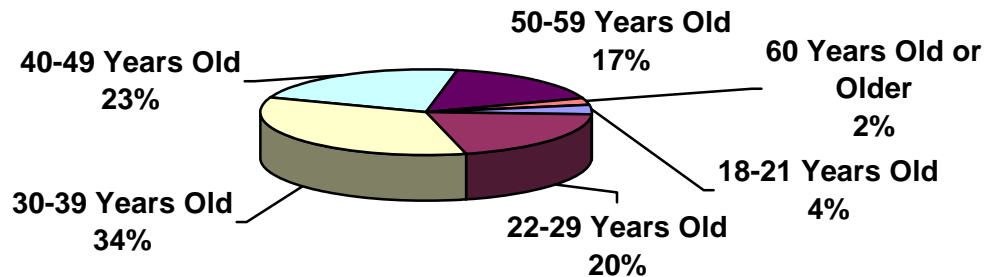
Focus Group Participation			
Organization	#	Who Participated	# Attended
 Consejo	1	Transitional Housing Residents	13
	2	Community Advocacy Program Participants	7
	3	Mental Health Consumers	9
	4	Mental Health Staff	13
	5	Domestic Violence Staff	5
	6	Managers	4
	Total participants		
 New Beginnings <small>living domestic violence</small>	1	Transitional Housing Residents	9
	2	Community Advocacy Program Participants	7
	3	Shelter Residents	4
	4	Shelter Staff	6
	5	Transitional Housing and Community Advocacy Program Staff	8
	6	Managers	6
	Total participants		
 <small>Proudly serving the LGBT Communities since 1969</small> Seattle Counseling Service	1	Addiction Services Consumers	7
	2	Mental Health Consumers	6
	3	Staff and Interns	22
	Total participants		
 sound <small>mental health</small>	1	Seattle Mental Health and Chemical Dependency Consumers	10
	2	Bellevue Outpatient Counseling Services, Case Management and Community Support Consumers	16
	3	South King County Outpatient Counseling and Chemical Dependency Consumers	7
	4	Seattle Staff	4
	5	Eastside Staff	17
	6	South King County Staff	10
	7	Managers and Directors	7
	Total participants		
Total # of Service Providers = 102		Total # of Service Recipients = 95	
Grand Total = 197			

○○○ Service Recipient Focus Group Demographics

Participants in the service recipient focus groups were asked to fill out demographics surveys. 87 out of 95 participants completed the survey for a response rate of 92%. This demographic data provides us with a better understanding of who participated and also gives us insight as to who is utilizing the services offered by our partners. The participation of marginalized groups such as Lesbian, Gay, Bisexual, Transgender and Queer individuals brought attention to issues around discrimination and access.

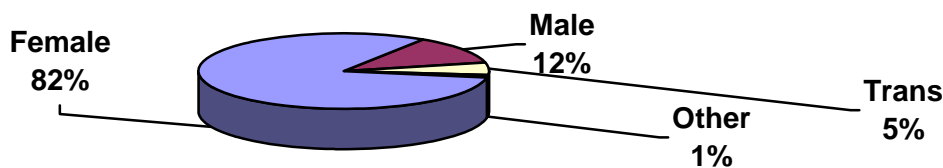
Age Range

Respondents varied in age with people between the ages of 22 and 59 being well represented among the participants. People at the extremes of the age ranges (18 to 21 and over 60) are underrepresented. This suggests that people in those age ranges may be underrepresented at the organizations overall. The chart below illustrates the age ranges of respondents.



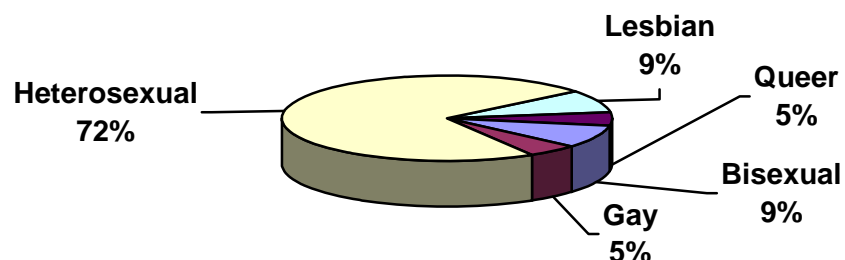
Gender / Gender Expression

The chart below illustrates respondents' answers to the question, "What is your gender / gender expression?" Most respondents were female, but we also had input from people who are male and trans / transgender. There is some overlap in these categories since some people who identified as trans / transgender also identified as female or male.



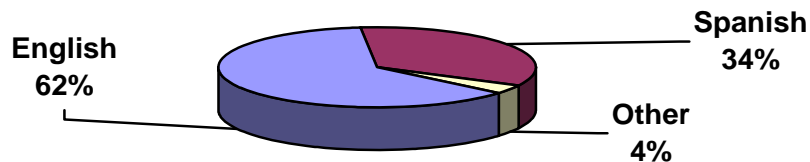
Sexual Orientation

The chart below illustrates respondents' answers to the question, "What is your sexual orientation?" The majority of respondents identified as heterosexual, but we also had input from people who identified as Lesbian, Queer, Bisexual, or Gay.



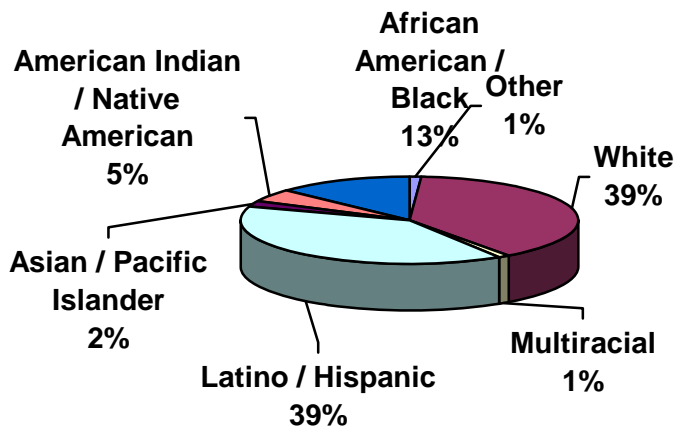
Primary Language

The chart below illustrates respondents' answers to the question, "What is your primary language?" Primary languages other than English or Spanish are not being listed because they could potentially identify specific individuals and subsequently put those participants at risk. Over one-third of respondents speak Spanish as their primary language. This is not surprising considering that one of the partner organizations, Consejo, serves people who speak Spanish as their primary language.



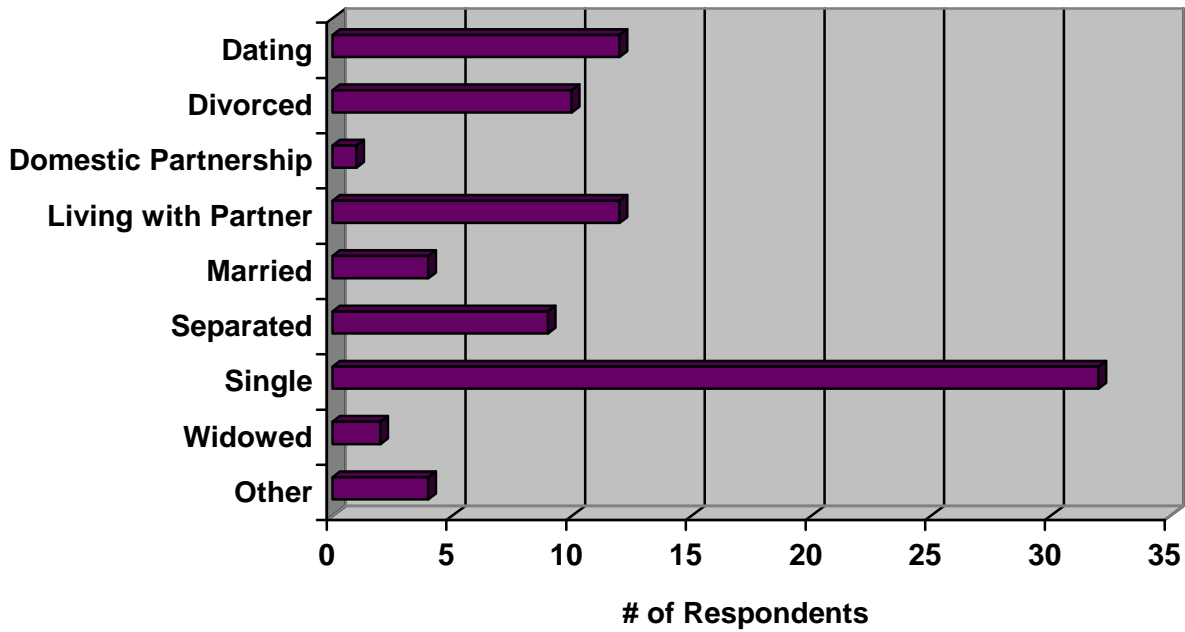
Ethnicity / Race

The chart below illustrates respondents' answers to the question, "What is your ethnicity / race?" While our collaborative recognizes that race is not a scientifically valid concept, we were interested in learning about the diversity of participants. As the chart shows, participants primarily identified as White and Latino/Hispanic. The proportion of Latino/Hispanic participants is not surprising considering Consejo's participation.



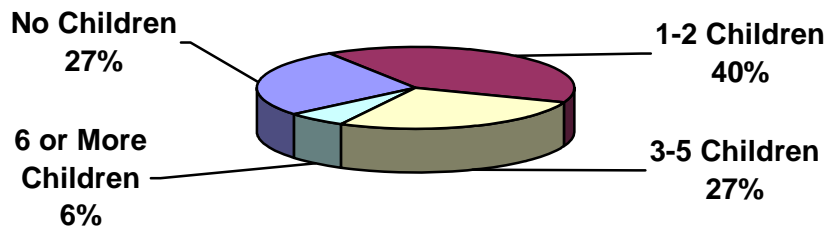
Current Relationship Status

Participants were asked their current relationship status. The largest percentage of respondents indicated that they were single, but there is wide range of responses overall. This indicates that services should be geared towards people of a wide variety of relationship statuses. The chart below shows their responses.



Number of Children

The chart below illustrates respondents' answers to the question, "How many children, if any, do you have?" While services for children are outside the scope of our project, it is noteworthy that nearly three-fourths of respondents are parents. Not surprisingly, concerns about children were frequently raised during our focus groups.



○○○ Implications of the Demographics Data

Our demographics data illustrate that the service recipients who participated in our need and strengths assessment come from a variety of backgrounds. Having their input is important because our project is committed to meeting the needs of survivors of domestic violence with mental health concerns who are from diverse cultures. Our vision is to be able to provide quality services to survivors of domestic violence who have disabilities in a manner that embraces their diversity.

Since Seattle Counseling Service is focused on meeting the needs of people who are Lesbian, Gay, Bisexual, Transgender and Queer, and since Consejo Counseling and Referral Service is focused on meeting the needs of immigrants who are Spanish speaking, these groups are a particular focus of our assessment. As marginalized communities, their needs often are not adequately addressed when evaluating services for survivors of domestic violence with mental health concerns or with other types of disabilities. We hope to improve services for all survivors with mental health concerns by focusing particular attention on these culturally specific groups. If organizations can meet their needs, then we believe they will be better equipped to meet the needs of other marginalized communities, as well as the needs of more mainstream communities.

○○○ Appreciative Inquiry Summit

We utilized the organizational change philosophy of Appreciative Inquiry to collect data from service providers at a day long summit meeting. The service providers who attended represented multiple levels within our partner organizations as well as key community stakeholders.

According to Appreciative Inquiry: A Positive Revolution in Change by David L. Cooperrider and Diana Whitney, Appreciative Inquiry (AI) is the cooperative search for the best in people and their organizations. It involves systematic discovery of what gives life to an organization or a community when it is most effective and most capable. AI involves the art and practice of asking unconditionally positive questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential.

At the AI Summit participants interviewed each other about accessibility, facilitating change, and working across organizations.

The 44 participants included:

- 32 people from our 6 partner organizations
- 8 community stakeholders
- 4 representatives from the Vera Institute of Justice and the US Department of Justice's Office on Violence Against Women

○○○ Online Surveys

We asked service providers and board members from Consejo, New Beginnings, Seattle Counseling Service and Sound Mental Health to complete online surveys. We surveyed board members to learn more about their organization’s readiness for change and their processes for creating change. We surveyed service providers about their experiences with providing services to survivors with mental health concerns, the challenges they have faced, and their ideas for improving services. Their input was necessary for us to be able to fully understand service provision at their organizations. We also believe they needed to have a voice in the process since the changes we will be making will directly impact them and not all of them were able to participate in the Appreciative Inquiry Summit or the service provider focus groups.

The response rates for the surveys far exceeded our expectations. We hoped that at least 25% of people who received the survey would respond. Please see the table below for the response rates for each group surveyed and for survey recipients as a whole.

Online Surveys				
Survey Audience	Organization	# of Recipients	# of Responses	Response Rate
Mental Health Service Providers	Consejo	15	12	80%
	Seattle Counseling Service	25	11	44%
	Sound Mental Health	350	80	23%
	Subtotals	390	103	26%
Domestic Violence Service Providers	Consejo	8	8	100%
	New Beginnings	36	22	61%
	Subtotals	44	30	68%
Board of Directors	Consejo	11	10	91%
	New Beginnings	15	14	93%
	Seattle Counseling Service	7	7	100%
	Sound Mental Health	18	9	50%
	Subtotals	51	40	78%
Totals		485	173	36%

○○○ About Service Provider Survey Participants

Respondents

People who responded to the online service provider surveys represent a variety of types of professionals within their fields. Their job titles are summarized below.

Domestic Violence Survey

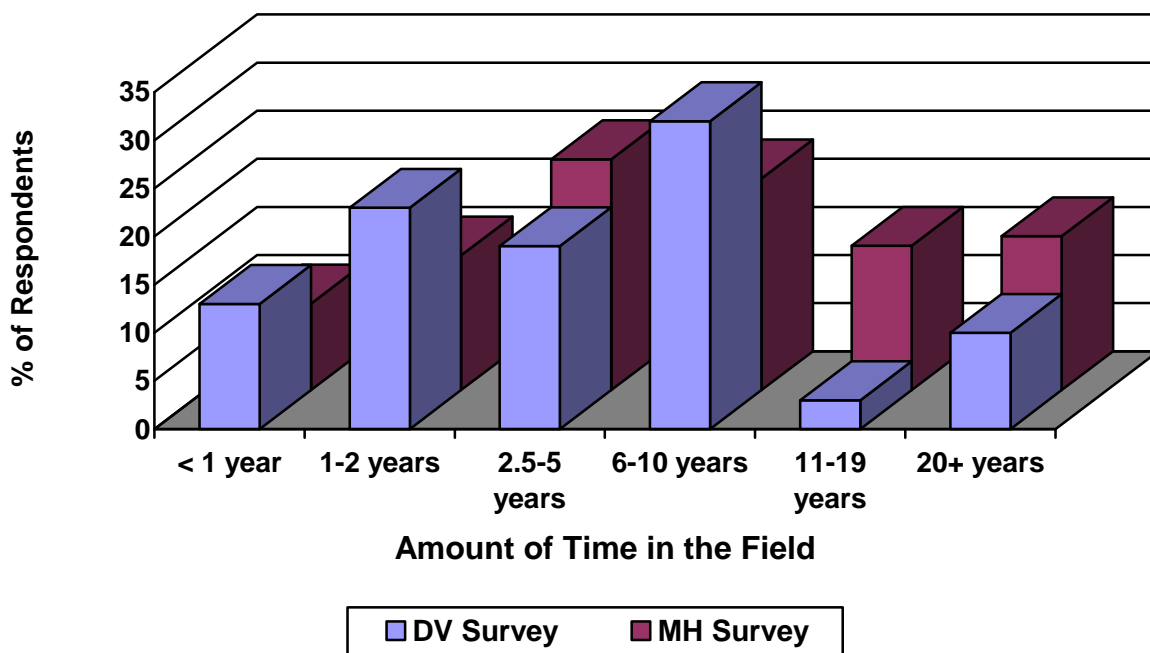
20 Advocates
6 People in Management
2 Support Staff
2 Others

Mental Health Survey

33 Therapists, Clinicians & Counselors
20 Therapists or Clinicians / Case Managers
19 People in Management
7 Interns
7 Medical / Health Staff
6 Chemical Dependency Staff
4 Peer Staff
7 Others

Time in the Field

Respondents represent people just starting in the field all the way up to those who have been in the field for over two decades. We were able to collect data from people who have a fresh perspective, those who are extremely experienced, and those in between. The pie chart below illustrates the range of experience of respondents.



○○○ Strengths, Challenges & Limitations

Our needs and strengths assessment was very successful both in terms of the depth and breadth of data collected and in terms of the diversity of people who participated in the process. We asked participants to provide us with information about their backgrounds (demographics for service recipients and professional roles for service providers.) By doing this, we were able to get a good picture of who was providing us with information. However, despite the large and varied pool of participants in the process, they are not a completely representative sample of all of the populations served by the partner organizations. For example, the service recipients who participated in the focus groups at Sound Mental Health were demographically fairly diverse, yet they represented only .3% of Sound Mental Health's total service recipients.

We conducted 3 of our focus groups in Spanish for Consejo service recipients who speak Spanish as their primary language. We chose to use Spanish speaking facilitators instead of using interpreters in order to make the experience as comfortable for the participants as possible. Unfortunately, we found it challenging to find facilitators who had the necessary skills and the availability to conduct the groups. As a result, scheduling these groups took more time than we expected.

We utilized simultaneous interpretation for a focus group at New Beginnings' transitional housing program, so English-speaking and Spanish-speaking residents could participate together in the same focus group. This allowed us to model the type of accessibility we are encouraging as part of this process of sustainable systems change.

We were fortunate to be able to create a comfortable environment for participants to share their ideas, thoughts, and concerns. While this enabled us to collect a great deal of meaningful data, it also was clear that participants were eager to spend time talking about their personal experiences with domestic violence. This was a challenge for facilitators since the time available for each focus group was limited and the need to share was quite strong.

The Appreciative Inquiry Summit was a success, but not in the way we expected. We anticipated that we would collect a great deal of data about the specific strengths of each partner organization related to serving survivors of domestic violence with mental health concerns. We ended up with more general information about the strengths of the organizations and what they value regarding working across organizations, facilitating change, and accessibility. It was not a goal of our meeting, but we were glad that the summit resulted in significant relationship building and much good will for our project.

We are aware that we are missing an important piece of the picture because we were not able to collect data from people who have never accessed services at the partner organizations, who have accessed services and then chose not to return, or who accessed services and were asked to leave. We feel this would be a valuable area to explore in the future.

Despite the challenges and the limitations we faced, we were able to obtain a great deal of very useful information. We were impressed with the generosity of the participants both in terms of the time they spent providing us with information and with their openness in giving us clear and honest feedback. As a result of their efforts, we were able to compile an extensive record of findings.

○○○ Process of Sharing Findings

Our collaborative took great care not just in how we collected data for our assessment, but in how we handled the information we collected. We did this out of respect for the people who participated in the process and out of respect for each of the partner organizations. The Project Coordinator oversaw all of the data collection. Focus group facilitators and note takers only had access to the data from the groups with which they assisted. The only other people to have access to the data were the staff from KCCADV. No names were attached to any of the comments recorded and information that appeared to be identifying was eliminated.

With the goals of the project in mind, the Project Coordinator compiled summaries of the data collected throughout the process. Information that was not relevant to the purpose of the project was not included in these summaries. The following steps were then taken to share the findings with the project partners:

1. The Project Coordinator met with directors from each of the partner organizations to discuss data collected from service providers and recipients at their organization.
2. Each organization's director decided what information would be shared with the collaborative as a whole and what information, if any, would only be shared within their particular organization.
3. Data that was approved to be shared with collaborative partners was shared at a meeting of the partners.
4. Findings were discussed among partners.
5. Some directors shared data with their staff.

The collaborative partners decided on this process collectively. The purpose of this process was to provide organizations the opportunity to have control over what information is shared with other organizations and what information is shared within their own organization only. All the partners agreed to aim for as much transparency as possible, but to respect that some information collected might only be useful to the organization it involved rather than the whole collaborative. For example, information that pointed out problems within an organization that were seen as unusual for that organization rather than symptomatic of how that organization generally operates was not shared. To avoid embarrassing any of the partners or creating unnecessary concern, the Project Coordinator did not share with the collaborative as a whole whether or not each organization fully disclosed the data about their organization.

The Project Coordinator reviewed all of the data that the collaborative agreed to disclose within the framework of the goals for the needs and strengths assessment (see page 6) and drafted a summary of the key findings that met the following criteria:

- They fit within the scope of the project
- They addressed the goals of the project
- They were common themes across the partner organizations
- They were identified as important issues by the participants in the needs and strengths assessment

The Project Coordinator reviewed the key findings with the partners and refined them with the assistance of the partners and staff from the Vera Institute of Justice.

○○○ 3 Key Questions

We found that the data primarily addressed three key questions about services for survivors of domestic violence with mental health concerns at our partner organizations:

1. Who can get in?
2. Do needs get met?
3. How can we do better?

1st Question – Who can get in?

This area of our findings addresses which survivors with mental health concerns are able to utilize services at our partner organizations. Concerns covered include:

- **Capacity** - Is there space or an opening for anyone?
- **Accessibility** – If there is space or an opening, will survivors with mental health concerns be able to utilize that space? Will the environment be welcoming to them, responsive to their language needs, and embracing of their diversity?
- **Screening & Assessment** – If you have the opportunity to get that space/opening, will you be directed to the services that you need?

2nd Question – Do needs get met?

This area of our findings addresses what happens once a survivor with mental health concerns gains access to a service provider. Accessing services does not necessarily equate to getting one's needs met. Here we are asking if service recipients are getting their needs met regarding domestic violence and mental health. This question covers concerns regarding:

- **Service Quality** – Are the services able to meet the service recipient's needs?
- **Collaboration** – If the program is not able to meet all of the service recipient's needs, then are service providers working with other providers (internally or externally) to get that person's needs met?

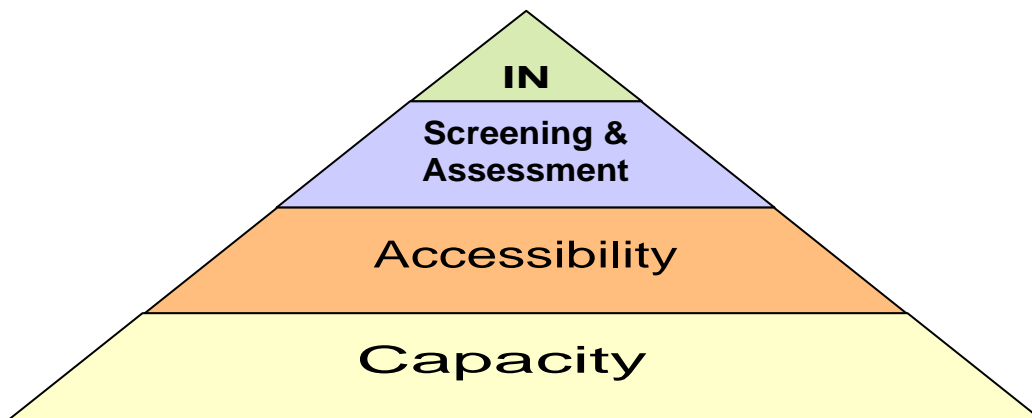
3rd Question – How can we do better?

This area acknowledges that we have room for improvement and addresses how we can create change. To address this question we identify:

- **Strengths** – What is each organization already doing well? How we can build on that? How can those strengths be shared with the other partner organizations?
- **Knowledge** – What do service providers need in terms of training, consultation, and policy changes in order to improve services?
- **Communication** – How can we improve communication internally and externally in order to improve services?
- **Readiness for Change** – What prepares us to create the sustainable systems changes that are the focus of this project?

○○○ Question # 1 – Who Can Get In?

As the pyramid below illustrates, when we address the question, “Who can get in?” we must first address the foundational issue of capacity. We can then look at accessibility, and finally, screening and assessment. Each one builds upon the ones beneath it to determine who gets in.



○○ Finding #1A- Capacity

Do organizations have the capacity to meet the needs of survivors with mental health concerns?

They told me that I need weekly therapy, and then they told me that they don't have room to give me services. I don't have the money or the insurance and they never had a space open anyways. – SMH Service Recipient

My counselor is wonderful. The only issue is that she's very booked, so it's hard to get in as much as I want to. – SMH Service Recipient

Demands on the partner organizations are so high that it is extremely challenging for them to address the complex needs of survivors of domestic violence with mental health concerns. Funders enable providers to offer services, but some of their requirements and policies can inadvertently act as barriers to survivors getting their needs met.

When service providers gave their input during the needs and strengths assessment process they repeatedly mentioned their commitment to better meeting the needs of survivors with mental health concerns. They also repeatedly brought up that their organizations are already stretched beyond their capacity and they cannot imagine adding one more thing to their already overflowing plates. They gave numerous examples of how busy they currently are and how they struggle with limited resources and insufficient staffing to meet the needs of the people they are serving. They

indicated that funding and funding requirements play a significant role in determining their capacity to improve services.

I don't think we serve as many people as we can because of the constraints of Medicaid. – SMH Service Provider

Mental health providers described being distracted from meeting the needs of their clients by an overwhelming amount of funding requirements and huge volumes of paperwork. Our partner organizations that are mental health service providers are primarily funded by Medicaid dollars distributed by the County. To receive this funding the providers must adhere to Federal, State, and County mandates. These mandates have grown significantly over the years and regularly change. Funded organizations are routinely audited to make sure that they are in compliance with these requirements. Providers stated that the time they are devoting to compliance and to preparing for audits takes away from their ability to meet the needs of service recipients. Documenting their services is much more time consuming than it used to be and every service provided must be documented. Many feel they are focused on meeting the needs of the funders rather than the needs of service recipients, and that it is often not possible to fully do both. For example, providers must ask service recipients (those receiving Medicaid funded services) if they have a dentist. If they do not, then service recipients must be provided with referrals for a dentist. If this is not related to why the service recipient is seeking services, then it may distract from the needs the recipient is trying to get met.

The executive director and senior staff are accustomed to adapting to changing funder policies and funding decisions, as is the board. Increasingly, though, the costs of compliance are stretching the staff and budget, and in some cases reduce time available to focus on clients. – Board of Director Survey Respondent

The County has added so many requirements that managers have to spend so much time doing audits. The focus has changed from seeing clients to dealing with paperwork. – Consejo MH Provider

We are doing a very good job, but we don't do our best because we are so busy. – Consejo MH Provider

Sound Mental Health has had to narrow the scope of who they serve in order to ensure that they are able to fulfill the obligations associated with receiving Medicaid. SMH is required to provide services within 14 days to people who qualify for Medicaid funded services. While this benefits people who have Medicaid, it means that SMH does not always have the capacity to serve non-Medicaid clients. Domestic violence survivors who do not qualify for Medicaid funded services, but who have insurance used to be able to obtain services at SMH. SMH's capacity to take clients using insurance has sharply decreased over the years as a direct result of this Medicaid compliance issue.

Capacity at domestic violence programs is limited by laws regulating the number of unrelated adults who can be housed at the same residence, as well as by funding and staffing levels. For example, domestic violence service providers in King County are not able to provide shelter to all survivors who request it. For every person who is provided emergency domestic violence shelter in King County, approximately 13 people are turned away. Domestic violence shelter and housing resources are kept at full capacity in part because of the high demand, but also because funders require that a certain number of bed nights be provided in order for providers to receive funding. If domestic violence organizations were to opt to serve fewer people in order to provide them with a more comprehensive level of service, then they would lose funding. This would result in fewer staff which would reduce the organization's capacity to provide services.

Domestic violence advocates also described struggling to balance the needs of survivors with serious mental health problems with the needs of other survivors and not being able to meet the needs of everyone. They explained that it often takes much more time to be able to assist someone with serious mental health problems than it does to assist someone with a higher level of functioning.

Staff is already maxed out. They have large caseloads and there's someone taking 75% of your time. What about the rest of the caseload? There's no one to pick up the slack. – NB Manager

They're here, but we don't have the resources to support them fully. – NB Advocate

Our systems are set up to fit people without mental health problems. You feel like you are failing them. – NB Advocate

Domestic violence program funders often require that funding recipients demonstrate certain positive outcomes. Advocates described how hard it is to achieve those positive outcomes with survivors who have serious mental health problems. Advocates described feeling like failures when they cannot report positive outcomes for all the survivors they are assisting. They do not feel they have the capacity to serve people with serious mental health problems at the level necessary in order to produce the required positive outcomes.

Holding us accountable based on numbers is overlooking the real cause of the situation. Clients aren't successful because there are other issues going on. It's not our fault or their fault. – NB Advocate

It's like we have to be successful and work miracles with every client. It's impossible. – NB Advocate

Capacity Implications:

The result of capacity limitations is that service providers are often forced to choose between providing more in depth services to fewer people or providing less service to more people. These limitations prevent providers from providing in depth services to all who need them. In this type of environment, people with more complex needs are less likely to get their needs met than people who have only one presenting issue. People who have experienced domestic violence and who have mental health or chemical dependency concerns are not likely to get their needs fully met if they cannot even get in the door or if the staff are too busy when they do manage to get in. If the person trying to get help has additional barriers to getting their needs met such as being undocumented, then the odds of getting their needs met decreases further.

Capacity Recommendations:

1. Capacity Assessments

To better understand how much capacity is an issue, partner organizations could conduct capacity assessments. An example of a capacity assessment resource is the Marguerite Casey Foundation's Organizational Capacity Assessment Tool. This tool measures four dimensions: (a) leadership capacity—the ability of the organization's leaders to inspire, prioritize, make decisions, provide direction, and innovate; (b) adaptive capacity—the ability of the organization to monitor, assess, and respond to changes; (c) management capacity—the ability of the organization's management to ensure effective and efficient use of resources; and (d) operational capacity—the ability of the organization's operations to implement key organizational and programmatic functions. Assessing these areas of capacity could assist organizations in determining what they are ready to do to improve services and what they need to work on in order to be able to make further changes, as well as sustain those changes.

2. Dialogue with Funders

It might also be helpful to discussing the findings from our needs and strengths assessment with key funders. Since funders and service providers tend to share the same goal of meeting the needs of service recipients, it could be helpful to engage funders in a dialogue about the impact of funding requirements on organizational capacity and on service quality.

○○ Finding # 1B - Accessibility

When organizations have the capacity to provide services, are survivors with mental health concerns able to access those services?

Each partner organization is strong in particular areas of accessibility.

Service providers and recipients were asked in focus groups about issues of accessibility for survivors of domestic violence who have mental health concerns. Service providers were also asked about this via online surveys and at the Appreciative Inquiry Summit. They shared the following positive comments:

Consejo excels in accessibility for low income Latino immigrants and refugees including those who are undocumented. All of Consejo's staff speak Spanish which makes it possible for people who speak Spanish as their primary language to arrange for and receive services. Consejo is also committed to providing services to people who are undocumented and who are therefore often ineligible for services from other organizations.

We can build trust quickly because people come to us and we speak their language. – AI Summit participant

Consejo is set up specifically for Hispanics which is really important. – Consejo Service Provider

Staff are bilingual and bicultural. – Consejo Manager

I really appreciate that services are in Spanish. – Consejo Service Recipient

New Beginnings excels in accessibility for immigrants and for people who do not speak English or who have limited English proficiency. New Beginnings utilizes simultaneous interpretation equipment at their transitional housing program, so that survivors who speak different languages can participate in support groups together. This is not yet a common practice in the area.

I have had a lot of translation services. It's been very helpful. – New Beginnings Service Recipient

They treat us all as Americans. – New Beginnings Service Recipient who is an immigrant

New Beginnings also excels in accessibility for people with mild or moderate struggles with mental health and/or chemical dependency. Service recipients had many positive things to say about the warmth, respectfulness and helpfulness of New Beginnings' staff. For many service recipients, this positive environment was a marked change from experiences they had with other service providers. Service recipients also shared steps

advocates had taken to help them get their mental health needs met including connecting them to therapists at other organizations, alleviating their anxiety, helping them get medications, and arranging for them to meet with a therapist on site. Another strength is that New Beginnings has a chemical dependency specialist on staff. Many service recipients noted how helpful that has been.

Everyone is so much more open, accepting and friendly here (compared to other shelters.) – NB Service Recipient

They helped me get back on my medications. I feel like I'm doing better now that I am back on. – NB Service Recipient

Seattle Counseling Service excels in accessibility for Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) people. Service recipients described experiencing hostile, homophobic environments when they have sought help from other organizations. They said they appreciate that the majority of staff and other service recipients at SCS are LGBTQ and that it is a safe place to be open about their sexuality and their gender expression.

I don't feel judged, not just because they're Gay, but I feel a connection with the community that's sitting here in the lobby. – SCS Service Recipient

Sound Mental Health excels in accessibility for people who are struggling with mental health and chemical dependency and for people who are low income. Service recipients shared that they experience discrimination in the world at large due to their struggles with mental health. They appreciate that they do not feel stigmatized at SMH and have a place to go where people care about them. They talked about how the services they receive help break down the isolation that people with serious mental illness often experience.

I know I have a mental disorder and I was really embarrassed about it. I've been really reluctant to get help. They let us know that there are a lot of people who are in the same situation. They are accepting and not assuming things so that you don't feel all weird. – SMH Service Recipient

Everyone is accepted at Sound Mental Health, treated like family. They teach us the importance of treating people with respect. – SMH Service Recipient

While each partner organization excels in some types of accessibility, they each have room for improvement in other areas of accessibility.

Service recipients and providers reported that discrimination, stigma, immigration status, and a lack of capacity are significant barriers to accessing services and to healing. Providers' attitudes and lack of understanding of domestic violence and mental health also presented as barriers to accessibility. The responses that follow are organized by the type of accessibility need.

Accessibility for survivors of domestic violence:

Domestic violence advocates pointed to the mental health system's funding requirements as a significant barrier to survivors being able to access mental health services. For example, the County requires mental health providers to diagnose their clients in order for their clients to be eligible for government-funded mental health care. The diagnosis must be serious enough to qualify for care. This can have major consequences for survivors. Fathers who perpetrate abuse have been successful in obtaining custody of their children when they are able to provide evidence that the children's mother has received such a diagnosis. The fact that the mental health problem was triggered by or exacerbated by the abuse perpetrated by the father is typically not taken into consideration in determining custody. Understandably, mothers who are aware of this may be reluctant or unwilling to obtain mental health care. Mothers who are not aware of this may feel betrayed by mental health providers when they encounter this backlash for getting help. If faced with a choice between receiving therapy and losing custody of their children, survivors will typically sacrifice their own emotional wellbeing. Advocates described struggling to assist survivors who have been traumatized, who appear to need mental health care, and who do not feel it is an option for them because of this risk. When survivors' mental health needs are unmet advocates often have a difficult time helping them get their other needs met.

People are looking for counseling, but they don't want to use their insurance and their Medicaid because they're afraid the abuser might find out about it. – SMH Service Provider

Mothers won't allow their kids to get services because they're afraid of losing their kids. – SMH Service Provider

They go and instead of talking to someone, they get diagnosed right away and now they hate the therapist and they never want to go to therapy. – NB Advocate

The diagnosis can be used against the victim in court and that's a big problem. – SMH Service Provider

Advocates described survivors telling them about receiving mental health services from therapists who blamed them for the domestic violence. This led to survivors not wanting to continue receiving services.

People who have experienced domestic violence and who are receiving mental health services may feel that their mental health needs are not fully being met if they are not given the opportunity to discuss the abuse. Focus group facilitators noted that mental health service recipients expressed a strong desire to get to talk about domestic violence. One facilitator noted that the focus group participants were "starving" for the opportunity to share their stories.

Accessibility for people with mental health concerns:

There is room for improvement in terms of accessibility to domestic violence services for people who have serious mental health problems. Advocates shared concerns about providing services to survivors who are not able to take care of themselves and do not appear to make any progress. They also expressed concern about how survivors with serious mental health problems impact other service recipients, particularly those in group living environments or in support groups. Advocates expressed discomfort with survivors who “shut down,” “snap,” become agitated, have trouble tracking, are delusional, and who call the crisis line chronically. They are concerned that they are harming survivors when they do not know how to help them, and they fear being physically hurt by mentally ill survivors. Advocates also expressed a desire to be able to stop serving some survivors when their mental health is too unstable. Multiple domestic violence service providers inquired, “Where do we draw the line?”

The women that we don't reach or don't feel successful with are mainly the women with severe mental health or chemical dependency issues. - Advocate

They could have us spinning out of control. – Advocate

It seems hurtful to say that we've reached our limit for what we can do for you. – Domestic Violence Manager

I'm very careful referring mental health cases to support group...They might disturb the group. – Advocate

They waste years with us being depressed and not engaging. – Advocate

Mental health and chemical dependency providers expressed concerns about how their clients are treated when they try to access domestic violence services.

Our clients who have serious mental health disorders and behaviors that are challenging are often discriminated against in the domestic violence system. They get kicked out of housing more often than people who don't have mental health and chemical dependency problems. Their ability to access shelters is more limited. The understanding of the domestic violence community about how to help someone that is paranoid or psychotic or bipolar is less than for other people. The system is not helpful to those people. – MH Manager

Accessibility for people who are Trans / Transgender:

Mental health service providers do not think that their transgender clients are welcome to access domestic violence advocacy services, particularly shelter. Trans service recipients feel that some mental health service providers are not sufficiently knowledgeable about trans issues. They also raised concerns about not being provided resources.

They didn't want to have this transwoman there "because really it's a man and men are dangerous." There has to be some sort of safe place for transwomen.
– MH Service Provider

For a transwoman client of mine...she's willing to stay with an abusive partner who throws knives at her because going to a shelter was so uncomfortable for her. – MH Service Provider

Counselor wasn't familiar with trans issues, didn't tell me about this group (referring to group for people who are transgender.) – MH Service Recipient

Transgender focus group participants talked about how they are not only at risk for violence in their intimate relationships, but they are also at risk in the world in general because of the discrimination and bias towards them. Being able to access services safely was clearly very important for them.

Accessibility for Lesbian, Gay, Bisexual and Queer people:

LGBQ survivors of abuse face barriers to accessing services due to homophobia, but also because service providers often rely heavily on gender / gender expression to make determinations about who is a survivor and who is a perpetrator of abuse. Many service providers start with the assumption that the survivor is female and the perpetrator is male. If a Gay man reaches out to a domestic violence service provider for help, he may perceive that he won't be helped because he is a man. If a Lesbian is able to access a domestic violence shelter, she may fear that her abusive female partner might also be allowed into the shelter.

Mental health service providers expressed the belief that there are no domestic violence services for Gay men. They were not aware that local domestic violence programs do serve men. Mental health service providers also shared that LGBTQ survivors of domestic violence who identify with an ethnic group may not feel comfortable accessing domestic violence services specific to their ethnic group because of homophobia and concerns about gossip in small, minority communities.

Hispanic Gay males are not comfortable going there because of their sexuality and their meth use. They are straddling three different cultures. They don't want to go there because if one person knows your business, then everyone knows your business. You don't want to go into a Hispanic community saying my boyfriend beats me up and I'm Gay. – MH Service Provider

Accessibility for people with limited or no English proficiency:

Service providers described how funding often does not take accessibility issues into account, particularly the cost, time, and expertise needed for interpretation and translation. Service providers and recipients described non-English speakers having less access to services and to interaction with other service recipients. While interpreters are available for individual sessions, there is a lack of access to interpreters for group sessions and for socializing opportunities.

Funding does not allow for the issue of language and interpretation. We have to translate and interpret all this information. – MH Manager

Non-English speakers are not able to participate in groups. – MH Service Provider

There's a man here who speaks Spanish. For Christmas I wanted to give him a card, but I can't. We should have an interpreter here [in the day room], so he could voice his thoughts. – MH Service Recipient

Accessibility for People of Color:

There wasn't much shared about accessibility issues for People of Color in general, but the quote below is particularly noteworthy:

On the rare occasions where there was someone who wasn't Anglo they don't stick around. . – MH Service Recipient

Service providers described how the lack of accessible and welcoming services in the community at large makes it much harder for service recipients to get their needs met, and puts more strain on the service providers who will help them.

When other organizations refuse to serve, inadequately serve, or discriminate against survivors with mental health concerns because of their behavior, immigration status, language knowledge, sexual orientation, gender expression, or other factors, then survivors may not be able to get their basic needs met. When their basic needs are not met (such as food and shelter), then their higher level needs (such as emotional wellbeing) are not likely to be met. For example, when an undocumented survivor of abuse cannot access housing resources, then the survivor may end up remaining in an abusive relationship and continuing to experience psychological trauma. This takes a toll on the survivor and also is quite frustrating for service providers who are unable to help her access services.

The majority of our clients only speak Spanish and the resources that we can connect them to are English-based. It's harder if they're undocumented. Everything is harder – employment, housing, schools, etc. – Consejo Manager

The clients feel frustrated because they think they can get all this help, but they don't realize that the legal issues (immigration status) are preventing them from getting what they need. They'll say, "Someone I know got this, this, and this. Why can't I?" – Consejo DV Advocate

There are agencies in the community that won't take people for many reasons: language, mental health, chemical dependency, etc. I think the burden on us wouldn't be so great if other agencies were providing services at the level that we are. – NB Manager

They need to try to appear very together in order to get services. Other service providers won't help her because she can't communicate what she needs because of her mental health issues. – NB Advocate

The environment in which services are provided does make a difference.

An organization may be open to serving all survivors with mental health concerns, but if that is not the perception of the community at large, service recipients and service providers, then survivors might not access the services. It is important for organizations to create environments that are welcoming to diverse survivors and to communicate that they are welcome. Service recipients were asked about their ideas for how organizations can create welcoming environments for survivors with mental health concerns. They offered these suggestions:

- Listen
- Prove to me that my information is confidential
- Provide stuffed animals
- Treat everyone like an American
- Provide options
- Do not assume that someone else has told me about what services are available
- Give me a handout that explains resources for us.
- I like when the doors lock. It feels safer.
- People in domestic violence situations are not comfortable in their own skin. You need people to encourage you.
- Put up a sign that says LGBT welcome or everybody is welcome. Think about what that means when you are inviting people to come to your agency.
- Setting should be warm, comfortable, inviting – not sterile, not like a hospital
- Comfortable seating
- Color on the walls
- Person at the counter should smile and treat you like a human being
- Tell me that if I am not getting what I need from the advocate I can talk to the supervisor.
- If you have a license or credentials, put it up on the wall.
- Give me information about you first before you start asking me questions.
- If you are not qualified to help me, then refer me to someone who is or tell me what you can help me with and what your are not clear about.
- Let me know what I can expect.
- Let me talk to the person I talked to before because I can't be expected to dive into it all over again.
- Offer to let me speak with someone else if I am not comfortable with the first provider.
- It's reassuring to have information available even if I'm not going to take it. It lets me know I am in the right place.
- Greet me when I arrive.
- Provide a private space with tissues. Don't make me sit in a waiting room with a bunch of strangers when I am in trauma.
- Don't push me to talk before I am ready.
- Don't give up on me.
- Reach out.
- Trust me like I trust you.



Accessibility Implications:

If partner organizations shared their expertise with each other regarding the areas of accessibility where they are each strongest, then accessibility for survivors with mental health concerns could be significantly improved. For example, if New Beginnings shared with SCS and SMH how they applied for and received funding for simultaneous interpretation equipment, then SCS and SMH could potentially obtain the same equipment and be able to offer group services to more of their service recipients who do not speak English fluently or at all.

Obtaining accurate information is necessary for optimal accessibility. If mental health service providers believe that there are no domestic violence services for Gay survivors of abuse, then they might tell that to their clients and those clients might not ever access domestic violence advocacy or shelter services. Service providers need to be clear about who their own organization serves and also about the services available at other organizations.

Discriminatory beliefs, attitudes, and behaviors need to be addressed to increase accessibility. For example, if advocates believe that people with serious mental health problems are likely to be violent, then they may be reluctant to serve them. If chemical dependency providers think that survivors are talking about the abuse they experienced in order to avoid taking responsibility for their substance use, then they may be reluctant to serve them. If mental health providers think that a client's experiences with abuse are a result of their own choices or a lack of communication skills, then they might not see the need to connect them to domestic violence services.

Accessibility Recommendations:

1. Provide Consultation
Each partner organization could provide consultation to the other partner organizations about the accessibility areas where they excel, so that each organization could improve their accessibility.
2. Eligibility Criteria
Each partner organization could provide the other partners with detailed information about eligibility criteria for their services and how people can access their services. This would enable organizations to provide their service recipients with accurate information about what services are accessible to them.
3. Attitudinal Accessibility
To improve attitudinal accessibility partner organizations could provide their staff with basic training about the diversity of survivors with mental health concerns and debunk some of the myths about them.
4. Accessibility Audits
Organizations could conduct accessibility audits focused on creating welcoming environments for survivors with mental health concerns.

○○ Finding # 1C - Screening & Assessment

If survivors with mental health concerns are able to access services, will they be directed to the services that they need?

A one size fits all approach to screening and assessment does not meet the needs of many service recipients.

Mental health consumers and people receiving treatment for addictions were asked about their experiences with being screened for domestic violence, since it is the policy of the partner organizations (the ones that provide mental health and chemical dependency services) to screen for domestic violence. Domestic violence screening is part of a comprehensive screening process where service recipients are asked a long list of questions related to their mental health and substance use. Clinicians and case managers might ask about domestic violence at another point in time if the service recipient mentions something about it, but it is not the practice of any of the partner organizations to routinely inquire about domestic violence after the initial screening. A few service recipients mentioned domestic violence being identified during couples counseling rather than prior to beginning couples counseling.

Domestic violence survivors were asked if advocates created an environment where they felt they could talk about mental health or substance use concerns. Answers ranged from survivors who felt they could discuss everything with their advocates to survivors who felt they could not say anything without repercussions. Survivors were not asked if they were screened for mental health problems because federal law prohibits service providers from asking about disabilities. Advocates expressed an interest in learning more about how to find out about survivors' mental health needs without violating the law.

Service providers were not specifically asked about screening or assessment practices, but some did address issues regarding identifying the need for domestic violence, mental health, or chemical dependency services.

In response to focus group questions about screening practices, service recipients advised providing opportunities for disclosure after trust and rapport have been established with the provider, and then only with a provider who is prepared to respond appropriately. While some participants described service providers who created a comfortable and compassionate space to talk about these issues, other participants could not recall being asked at all or described being asked in a less than ideal way. The approach of service providers within the same organization and across organizations was not consistent. Both service providers and recipients acknowledged that not all providers were prepared to respond to service recipients who shared experiences with domestic violence or who had mental health concerns.

Why would women disclose mental health information to someone who doesn't know what to do with that information? – NB Advocate

We don't even know what questions to ask to find out what the issues are. – NB Manager

They kind of asked, but they don't know what to do about it. I was expecting more of a "now what?" – SCS Service Recipient

They just went through the questions and moved on after they heard yes or no. – SMH Service Recipient

I would not have wanted to talk about domestic violence after just meeting the counselor that day. – SMH Service Recipient

I thought for all the time the intake took maybe they were picking an appropriate counselor for me. Participant expressed disappointment that there wasn't a connection between what was shared and the clinician assigned. – SCS Service Recipient

Be open to the idea that people have a variety of issues, not just what they are being seen for. – Consejo Service Recipient

The more all of us are aware of what we're looking for, the better we can provide this care. – SMH Manager

I think we could improve the way we assess for domestic violence and safety. – SMH Manager

I think that simplifying the process as much as possible as far as admitting someone into the system is crucial. I had to jump through hurdles. I had to wait. I had to talk to a lot of people to get into both the mental health and the chemical dependency programs. – SCS Service Recipient

If someone assumes that you don't have these things, it's harder to say that you do. – SMH Service Recipient

There are a lot of interns and they are not educated in domestic violence. They may not ask the questions or even know what the questions are. – SMH Service Provider

Screening & Assessment Implications:

Since screening is not being done consistently nor in a way that meets the needs of service recipients, it would be worthwhile to re-evaluate the process at each organization and to work towards a more effective approach. Service recipients indicated that opportunities for identifying the need for mental health or domestic violence services should be available at multiple points, and that the conversation needs to take place with someone who is knowledgeable and who is trusted by the service recipient. If service recipients are not being carefully screened for domestic violence prior to beginning couples counseling, then this needs to be addressed.

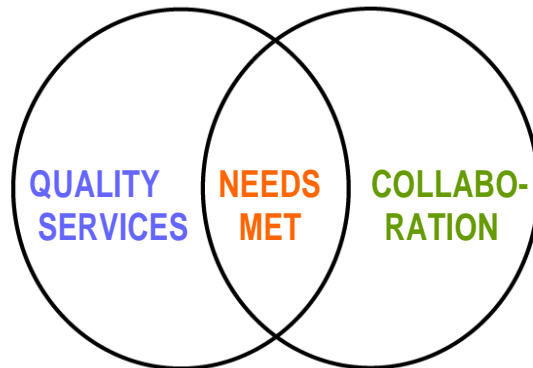
Screening & Assessment Recommendations:

1. Review Screening Practices at Domestic Violence Programs
Review screening practices at domestic violence programs to ensure that they are consistent, compliant with federal and state disability law, and utilize best practices.
2. Review Screening & Assessment Practices at Mental Health Program
Review screening and assessment practices at mental health programs to ensure that they are consistent and utilize best practices.
3. Develop Protocols for Ongoing Screening
Identify opportunities post-intake to inquire about the need for domestic violence and mental health assistance. This would enable people to be screened after they have developed rapport and trust with their service provider and prior to receiving couples counseling.
4. Train Staff on Responding to Screening & Assessment Disclosures
Staff could be given training on how to appropriately respond to disclosures of domestic violence and mental health concerns.

○○○ Question # 2 – Do Needs Get Met?

If the conditions are right for survivors with mental health concerns to be able to get services (there is sufficient capacity, services are accessible, and they have been screened in to the appropriate services), then will they be able to get their domestic violence and mental health related needs met?

As the Venn diagram below illustrates, needs get met when quality services and collaboration overlap.



○○ Finding # 2A - Service Quality

If survivors with mental health concerns are screened in to services, then will those services be of sufficient quality to meet their needs?

Service recipients want integrated, quality services that support them as a whole person.

Service recipients and providers were asked what about the services being offered is working well and what needs to be improved. They reported that services can be challenging to navigate and disjointed. A service might focus on one aspect of their needs (e.g. their domestic violence experiences) without addressing their other needs (e.g. their mental health.) Service recipients reported feeling overwhelmed by trying to access services at multiple organizations in multiple locations in addition to taking care of everyday needs.

Services need to be better integrated. – Consejo Service Provider

Service recipients greatly appreciate when multiple services are offered at the same location, particularly if the location is where they are residing. For example, Healthcare for the Homeless offers limited mental health counseling at New Beginnings' emergency shelter. Residents explained that it is scary for them to leave the safety of the shelter to receive other services, and that having counseling on site made it possible for them to get more of their needs met.

Medical, mental, chemical dependency, all of it is addressed at once instead of trying to address one at a time. – SMH Manager

One thing that has always worked is the fact that we have services for mental health and for domestic violence and that it's all in house. – Consejo Manager

The services need to be all together. Providers need to understand the demands that are on your life. – NB Service Recipient

In order for services to be well integrated, referral processes need to be improved.

Service recipients were asked about their experiences of being connected to services at other organizations. Some referrals to other organizations and within the partner organization are effective and helpful.

She really went out of the way trying to get me help after I left him. The counselor found the housing with me. – SMH Service Recipient

However, many service recipients expressed a need for referrals that are specific, detailed, and involve organizations that have pre-existing and trustworthy relationships with their current service providers. They also expressed a need for their service provider to assist them in making the connection. This assistance appeared to be of particular importance to people experiencing a great deal of crisis, people who do not have telephone or computer access, and people who are struggling with serious mental health problems. Service recipients generally did not feel it was very helpful for a provider to hand them a list of phone numbers for programs that might be able to help them or to merely print out information from the internet for them.

Service providers expressed some frustration over challenges with internal referrals, particularly with receiving referrals they perceive to be inappropriate or referrals with insufficient information about the situation.

We get a lot of referrals. That's not the problem. The problem is that the referrals are for clients who don't come back. – Consejo Manager speaking about referrals from Consejo's domestic violence program to Consejo's mental health program

It's important to be able to distinguish when a client is ready for counseling... They will come one time and then I don't see them again. – Consejo MH Provider

I think I have worked with more people that are survivors of domestic violence than I am aware of. It's not something that the case manager has told me or it is very vague in their crisis plan. – SMH Service Provider

Service providers also expressed frustration with trying to assist service recipients with getting services from other organizations.

Who can we refer them to? Will the therapist understand domestic violence? It's usually not just one or two therapists that don't get it. – NB Advocate

I don't know what the screening criteria are for the shelters that we are calling. (Advocates wouldn't tell her.) - SCS Service Provider

Services need to be strengthened in order to better meet the community's needs.

Despite the feeling that there is not the capacity to expand services, service providers did recommend ways in which services should be augmented. Domestic violence providers would like survivors to be able to access trauma therapies (e.g., EMDR) at community mental health organizations. Domestic violence and mental health service providers and service recipients all expressed a desire for support groups and for culturally-specific services. While some of the partner organizations do offer support groups, not all do. None of the partner organizations offer support groups that are specifically geared toward survivors of domestic violence with mental health concerns. New Beginnings does offer a support group for survivors of domestic violence with chemical dependency concerns. Multiple mental health service providers said they would be interested in co-facilitating support groups with an advocate, so that survivors with mental health concerns could get the support they need.

I would like to see a push for support groups. – Consejo MH Provider

There's a great need for trans and queer friendly shelters. – SCS Service Provider

They should start a support group for people with mental health issues and domestic violence. – SMH Service Recipient

I'd like to see a domestic violence support group at every site. – SMH Service Provider

Service Quality Implications:

Our findings indicate that service recipients prefer to have their needs met by one organization at one location if at all possible. If that is not possible, then they want assistance getting connected to other services. Support groups, in particular, appear to be a service that could better meet the needs of survivors with mental health concerns if the group was designed to address both domestic violence and mental health. Since mental health providers have expressed an interest in offering such groups, then it is worth exploring this as a possible way to improve services.

Since service recipients indicated a need for accurate, comprehensive referrals to trustworthy providers, service providers might want to rethink how they are providing referrals. Printing out information from the internet or photocopying a list of phone numbers might appear to be an efficient way of connecting people to other services. However, if quick methods of providing referrals do not result in service recipients actually receiving additional services, then they are not in fact a good use of time.

Service Quality Recommendations:

1. Increase Co-Location of Services

Organizations should identify if it is possible for them to provide additional services at their current locations rather than referring people to other organizations at other locations to get their needs met. This could also mean that organizations have staff that travel to other locations to provide services. For example, a mental health provider could travel to a domestic violence shelter to provide therapy on site or a domestic violence advocate could meet with service recipients at the mental health organization where they are receiving services.

2. Support Groups for Survivors with Mental Health Concerns

Organizations could offer support groups that are co-facilitated by domestic violence and mental health service providers that address the needs of survivors of domestic violence who have mental health concerns.

3. Improve Referrals

Protocols for improving referral processes could be developed. The expectation could be that service providers will directly connect service recipients with other providers whenever possible unless the service recipient does not want this assistance. Directly connecting a service recipient could involve calling the other provider together or physically going to the other provider's location together.

4. Use Liaisons

Partner organizations could identify staff to function as liaisons with the other partner organizations to assist providers in accessing services and making referrals.

5. Trauma Informed Care

Mental health organizations could assess if they are providing trauma informed care to their service recipients who have experienced domestic violence. Evidence-based treatment modalities should be made available to survivors.

○○ Finding # 2B - Collaboration

If a program is not able to meet all of the survivor's needs, then are service providers working collaboratively with others (internally or externally) to get that person's needs met?

Philosophical differences, trust and bias concerns, confusion about roles, and confidentiality and capacity issues can be barriers to collaboration between domestic violence and mental health service providers.

Service providers attending focus groups were asked about their positive experiences collaborating with other providers to meet the needs of survivors with mental health concerns. They were also asked about barriers to working collaboratively and what needs to be done to remove those barriers. They identified times when collaborations have worked well, but they also expressed challenges bridging the differences between the fields of mental health and domestic violence.

They described philosophical differences including:

- Mental health providers feel that domestic violence advocates are inappropriately directive with their clients rather than encouraging them to make choices for themselves.
- Domestic violence advocates feel that therapists blame survivors for the abuse they have experienced.
- Mental health providers feel advocates treat clients like victims and do things for them that they are capable of doing for themselves.
- Domestic violence advocates feel mental health providers unnecessarily diagnose clients.

We have to diagnose anyone who is getting services. It creates a lot of friction with advocates. – SMH Service Provider

- Mental health providers feel that domestic violence advocates are unwilling to accept their clients' diagnoses.
- Mental health and domestic violence providers have different priorities and goals for their clients.

There is a big split between the domestic violence service community and the mental health service provider community and then a split between chemical dependency. – SCS Service Provider

Crisis is defined differently in domestic violence than it is in mental health. – Consejo Manager

It's difficult to send clients out for other services knowing there are different attitudes toward what they should be doing. – SMH Service Provider

In domestic violence they say the abuser is the problem, but I can't do anything about the abuser. – SMH Service Provider

Some service providers also shared concerns regarding trust and bias. While advocates' comments about mental health providers being victim blaming does indicate distrust, advocates primarily shared that they feel discriminated against by mental health providers. Mental health providers, on the other hand, did indicate numerous concerns about advocates. Domestic violence advocates said they feel like mental health providers are condescending towards them and devalue them based on their education level. This perception appears to have some validity considering the comments made by some mental health providers. These comments included:

- Advocates are not capable of understanding mental health issues or how to respond to them appropriately.

If you are a bachelor's level case manager, can you look at the systems and the mental health issues and actually create a safe plan for that person? – MH Service Provider

I could feel them thinking my perspective wasn't as valid. – NB Advocate talking about mental health professionals

- Advocates should be required to have more education.

There was a lot of disdain because of the level of education that counselors need to have compared to advocates. – NB Advocate talking about mental health professionals

- Advocates do not trust mental health providers because they serve both victims and perpetrators.

We provide services to perpetrators as well, so that consistently poses a problem regarding trust. It's a hurdle we have to get over. We do that too AND we're safe. Domestic violence agencies don't consider us a safe environment for their clients and they don't think that we have the expertise. – SMH Manager

- Advocates stigmatize people with mental health problems.

There is a pervasive attitude on the part of advocates that referring someone to mental health services is a bad thing. The stigma of mental health, which we deal with all the time anyway, seems to be very much alive and thriving and reinforced inside the domestic violence arena. – SMH Manager

- Advocates discriminate against people with mental health problems.

Our clients don't last very long where there are strict rules about behavior. Largely it is because of a lack of flexibility around mental health issues. – SMH Service Provider

- Advocates are biased against men.
- Advocates are biased against mental health professionals.

We see ourselves as the good guys who are helpful and the fact that advocates see us as evil doers is really difficult. – SMH Manager

Interestingly, some advocates feel that mental health providers are currently less disdainful of them than they were in the past.

There was a lack of respect, but we talked about it and resolved it. I don't feel like they are being condescending to me anymore. – Consejo DV Advocate

Service providers also expressed concerns about role confusion. These concerns included:

- Service recipients do not know the difference between what an advocate does and what a mental health provider does

It's difficult to deal with a person who has mental health problems that is in a relationship that is very violent because sometimes they want you to be their therapist and we're not therapists. – Consejo DV Advocate

What is an advocate? – SCS Service Recipient

- Disagreement between providers about who is responsible for providing case management
- Disagreement between providers about who is responsible for determining if a survivor is ready for and in need of mental health services

Issues were also raised by service providers about confidentiality. Concerns included:

- Advocates felt that mental health providers were withholding of information even when the service recipient has signed a release of information form.
- Advocates felt that service recipients would not be comfortable with the advocate and the mental health provider talking about them when they are not present.
- Mental health providers felt that advocates adhered to confidentiality even when it was not in the best interest of the service recipient.

It seems silly when two professionals working inside the same agency with the same client can't share information. – Consejo MH Provider

Providers also talked about capacity issues in terms of collaboration.

In times of stress the piece that drops out is coordination. It takes time to coordinate. – SMH Manager

Participants at the Appreciative Inquiry Summit were asked about their best experiences working collaboratively across organizations and what they have learned about successful collaborations.

It is important that collaborating agencies have trust, as well as a shared vision. – AI Summit Participant

Communication and follow through are essential in trust building across organizations. – AI Summit Participant

Participants at our Appreciative Inquiry Summit identified the following as important for successful collaboration:

- Commitment & Motivation
- Communication & Connection
- Support
- Attitude & Values
- Leadership
- Resources & Skills
- Action
- Culture & Diversity

Collaboration Implications:

The philosophical differences mentioned during the focus groups were not surprising considering the different ways that the two fields train their professionals and the differences in focus between the two fields. There has also historically been some tension between the two fields. The trust and bias issues raised suggest that there is still a lack of understanding between the domestic violence and mental health fields about how each approaches their work, why they approach it that way, and the skills and knowledge needed to do the work. Fortunately, there are also indications that providers are interested in understanding each other better and working together to meet service recipients' needs.

Both domestic violence and mental health providers talked about wanting to empower service recipients to make choices for themselves. It was somewhat surprising though that mental health providers criticized domestic violence providers for not doing this considering that empowerment is a core value of the domestic violence movement and not something domestic violence advocates perceive mental health providers caring about. The confusion about roles appears to be an issue both between the systems and within organizations.

The confidentiality concerns appear to be partly about the issues mentioned above and partly about a lack of understanding about the laws pertaining to confidentiality for each profession. Encouraging conversations, when appropriate, where both providers and the service recipient all discuss the needs of the service recipient may alleviate some of these concerns.

Collaboration Recommendations:

1. Address Information Sharing Practices

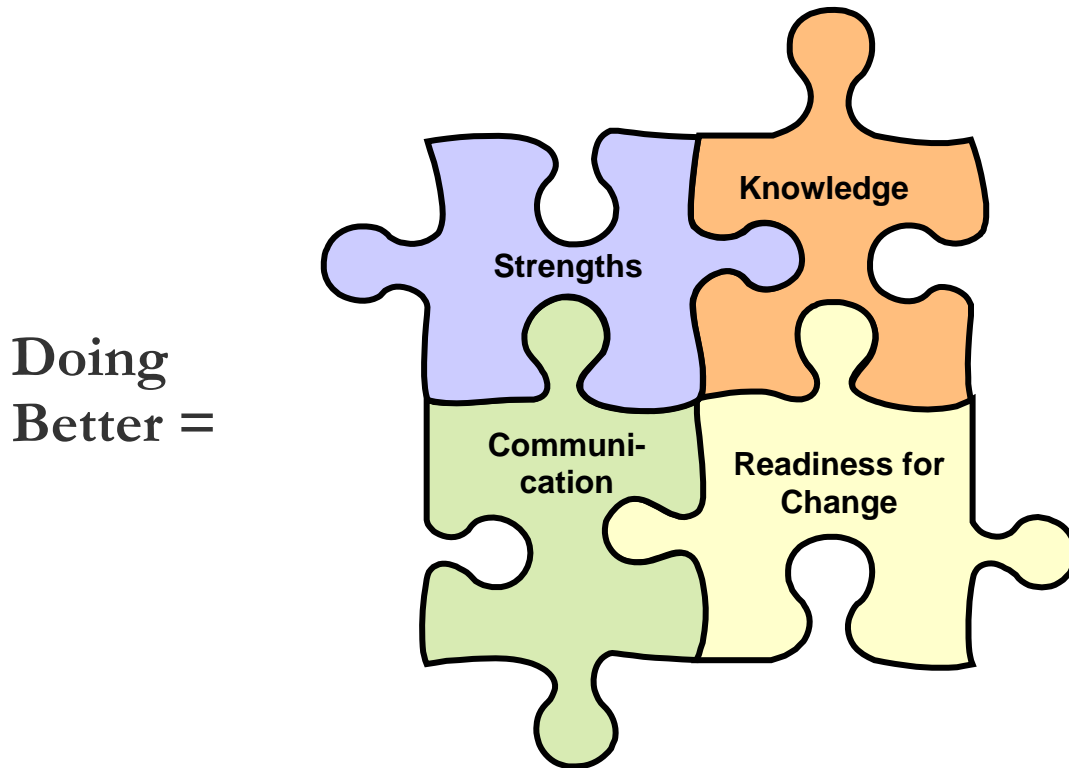
Review each program's release of information forms to determine if they are clear and appropriate for information sharing between professionals. Educate providers about the laws and best practices regarding confidentiality for mental health providers and confidentiality and privilege for domestic violence advocates. Encourage providers to involve the service recipient in all decisions about sharing of information and to participate in the calls or meetings between providers when appropriate.

2. Clarify Roles

Ensure that job descriptions are up to date and clear. Share information within and between organizations about the roles and responsibilities of each type of service provider. Educate providers about the philosophy of each profession and why each type of provider has their specific role.

○○○ Question # 3 – How Can We Do Better?

As the puzzle pieces below illustrate, we can do better by piecing together our strengths, knowledge, good communication, and readiness for change.



○○ Finding # 3A - Sharing Strengths

Partner organizations each have valuable expertise and strengths that could benefit the other partner organizations.

The partner organizations participating in the project were each selected by the City of Seattle because of their commitment to improving services for survivors with mental health concerns and because they are well known in the community for their areas of expertise. From the onset of this project the collaborative partners have recognized the importance of sharing their strengths with each other, so that all the participating organizations can work more effectively and better meet the needs of the community. Not surprisingly, the strengths that made the partner organizations ideal for this project were also identified and described during the needs and strengths assessment process by their boards, their service providers, and their service recipients.

We have things to offer each other. We just need to do it efficiently. – Consejo MH Provider

The findings about each partner included the following:

The City of Seattle Human Services Department, Domestic Violence and Sexual Assault Prevention Office creates opportunities for change in the domestic violence and sexual assault communities by promoting and funding collaborative projects. Their research, planning, and partnership have allowed community organizations to do more, to do it better, and to work more effectively together.

Consejo's bilingual and bicultural staff have expertise in serving Latino immigrants and refugees. Since a substantial portion of their service recipients are undocumented and therefore ineligible for many community and government services, Consejo staff exercise a great deal of resourcefulness in meeting their needs. Consejo offers innovative and comprehensive care including domestic violence, mental health, and chemical dependency services, as well as opportunities for healing through art, social interaction and acupuncture.

The King County Coalition Against Domestic Violence is a respected leader in the local domestic violence and human services community. The Coalition is known for its domestic violence expertise, its ability to leverage funding, and its influence for positive social change. The Coalition brings the local domestic violence community together by offering mechanisms for connection and collaboration between domestic violence agencies.

New Beginnings is highly respected for the quality of their domestic violence services. They have had great success in providing respectful, supportive, and transformational services through their social change program, community advocacy program, emergency shelter, and transitional housing program. Their expertise in responding to the chemical dependency struggles of domestic violence survivors is particularly noteworthy.

Seattle Counseling Service has created an environment that allows Lesbian, Gay, Bisexual, Transgender, and Queer individuals to feel safe enough to address their struggles with mental health and addictions. Their dedicated staff have a sophisticated understanding of issues of oppression and the complexity of addressing them.

Sound Mental Health has an impressive array of programs and approaches to meeting the mental health and chemical dependency concerns of their clients. They have tremendous resources in terms of the breadth of the knowledge and expertise of their staff, the mechanisms they have in place for operating and the relationships they have built with other community providers.

The size of the agency works for us. Even if I don't know how to do something, there are a couple hundred people I could ask. –SMH Service Provider

Sharing Strengths Implications:

Our partner organizations are impressive and resourceful. They offer a great deal to the community and have much to offer each other. By identifying the strengths of each organization, the partners are well positioned to build on their own existing strengths and to learn from each other.

Sharing Strengths Recommendations:

1. Build on Strengths

Organizations could explore how they can sustain their areas of greatest strength and how they can further develop those strengths.

2. Provide Consultation

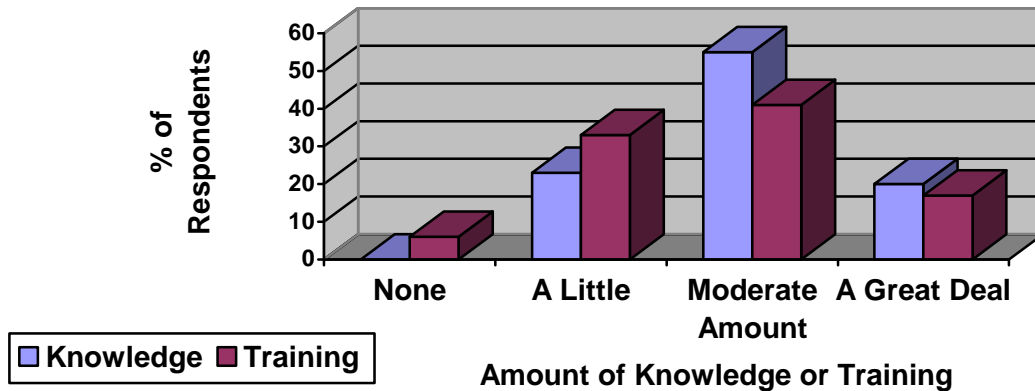
Each partner organization could provide consultation to the other partner organizations about the areas where they excel, so that each organization could improve their services.

○○ Finding # 3B - Knowledge

Service providers need more training, more consultation, and better policies in order to improve services for survivors of domestic violence with mental health concerns.

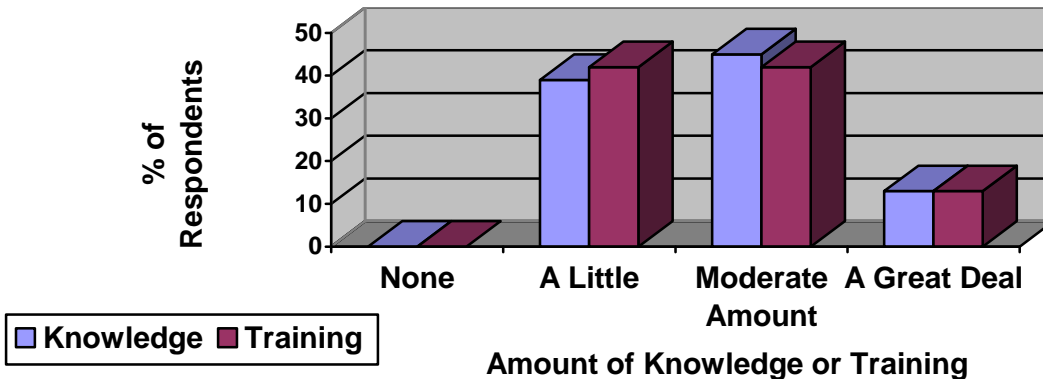
Knowledge & Training Regarding Domestic Violence

Mental health service providers were asked in an online survey to rate how much knowledge they have about domestic violence and how much training they have received on domestic violence. The chart below illustrates the results. A high percentage of providers, 76%, feel they have a moderate amount or a great deal of knowledge about domestic violence, yet only 58% report having received a moderate amount or a great deal of training about domestic violence. Similarly, while 6% report having received no training about domestic violence, no one reported having no knowledge about domestic violence.



Knowledge & Training Regarding Mental Health

Domestic violence service providers were asked to rate how much knowledge they have about mental health and how much training they have received on mental health. The chart below illustrates the results. Domestic violence providers' estimations of their knowledge and training were more modest than the estimates of mental health providers. Also notable is that their ratings of their training and their knowledge were more consistently the same.



When responding to questions about improving services, service recipients shared thoughts about providers' need to increase their knowledge

Advocates need to have realistic expectations about what medications can do and the time it takes to work. For some people the pills don't work at all. – SCS Service Recipient

They really need to read the literature. – SCS Service Recipient describing the need for service providers to educate themselves about the communities they are serving in general and the transgender community in particular.

I don't feel like domestic violence advocates have knowledge about mental health issues. – SMH Service Recipient

Service providers at focus groups also indicated a need for increased knowledge. They were asked what makes it difficult for them to meet the needs of survivors with mental health concerns and what would better equip them to meet those needs. Service providers talked about both the need for more training and the barriers to obtaining that training. Barriers included competing demands, lack of culturally specific trainings, and lack of funding for training.

We are invited to the trainings in the mental health department, but we don't have any time. Everybody is so swamped with clients that we don't have time for that. – Consejo DV Advocate

The trainings are out there, but the problem is finding trainings that work with Latina communities. – Consejo MH Provider

One limitation is the amount of training we get. We only get a certain dollar amount per year. – SCS Service Provider

Service providers also pointed out that training is most helpful when it is program specific and responsive to the organization's needs.

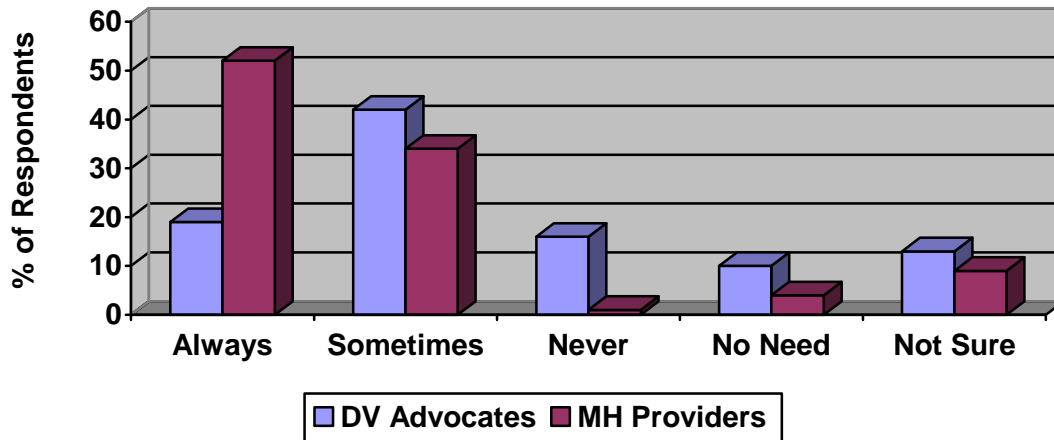
Most of our staff have had domestic violence 101 several times, but it doesn't cover how to use that within each of our sectors and how to meet our requirements mandated by the mental health aspect. – SMH Manager

In addition to formal trainings, consultation is another important way that service providers obtain information about how to best provide services. Service providers were asked via online surveys about the availability of consultation and who, if anyone, has provided them with consultation.

As the chart below illustrates, mental health providers are much more likely to have access to consultation than domestic violence advocates. 86% of mental health providers reported always or sometimes having consultation available to them

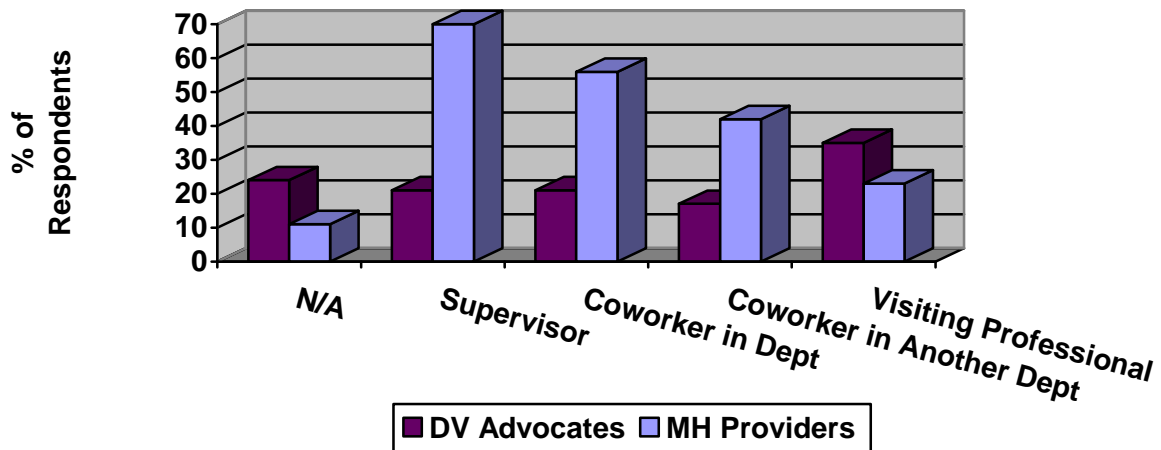
compared to 61% of domestic violence advocates. It is also noteworthy that domestic violence advocates are more likely to not see a need for consultation (10% of advocates responded that way compared to 4% of mental health providers.) Unfortunately, a sizable percentage of both types of providers did not know if consultation is available to them (13% of advocates and 9% of mental health providers.)

Availability of Consultation
on MH for Advocates & on DV for MH Providers



In response to the survey questions about who provides them with consultation internally, many respondents indicated that they have multiple people within their organization who they can go to for consultation. The person domestic violence advocates are most likely to go to for consultation about mental health issues is a visiting mental health professional. The person mental health providers are most likely to go to for consultation about domestic violence issues, is not a domestic violence professional, but their supervisor. See the chart below for an overview of the responses.

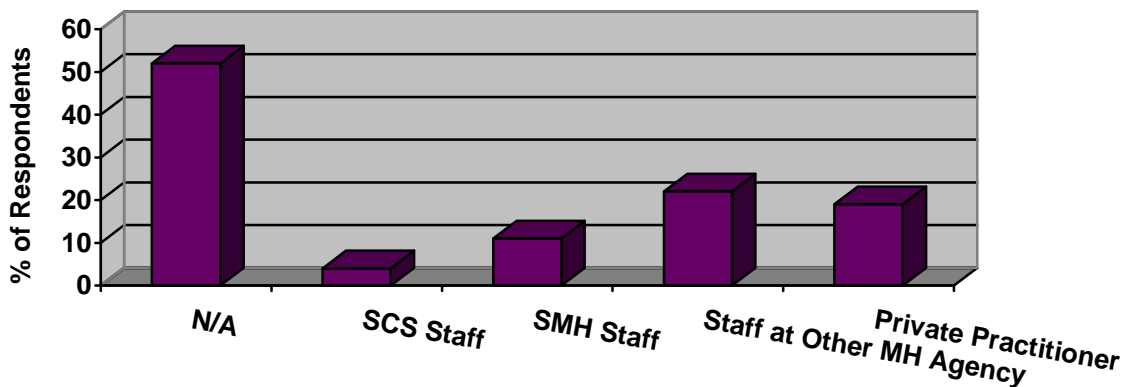
Consultation Provided Internally



In response to the survey questions about who provides them with consultation externally, twice as many advocates responded that this was not applicable to them compared to their responses regarding internal consultation. Three times as many mental health providers said this was not applicable to them. Yet, a greater percentage of mental health providers did seek out external consultation (66% compared to 48% of domestic violence advocates.)

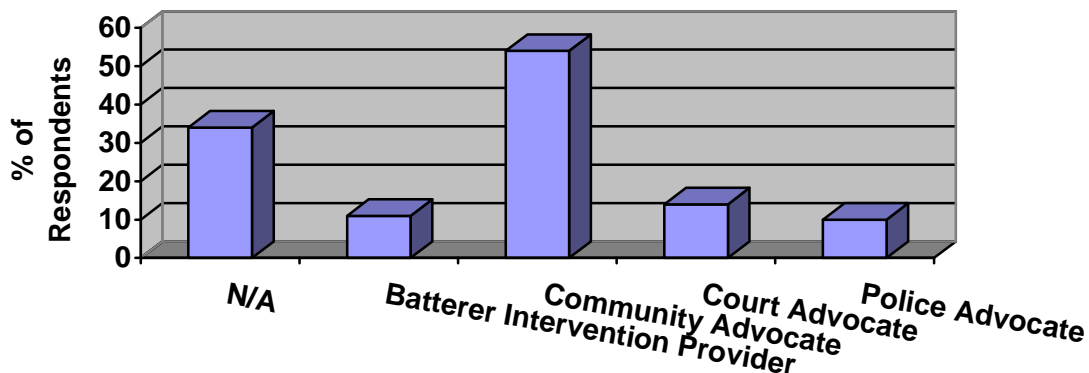
The first chart regarding external consultation illustrates the responses of domestic violence advocates. Out of the 48% of advocates who consulted with an external provider about mental health issues, approximately 15% indicated seeking consultation from mental health professionals at partner organizations Seattle Counseling Service and Sound Mental Health. 22% said they have received consultation from another community mental health agency. A slightly smaller percentage said they had received consultation from mental health professionals in private practice.

Consultation Provided Externally to DV Advocates



The second chart regarding external consultation illustrates the responses of mental health providers. Out of the 66% of mental health providers who consulted with an external provider about domestic violence issues, the majority consulted with a community-based domestic violence advocate. 14% consulted with a court-based advocate and 10% consulted with an advocate at a police department. 11% reported consulting with a batterer intervention provider.

Consultation Provided Externally to MH Providers



Service providers discussed the challenges involved with serving both survivors and perpetrators within the same organization. While organizations are working to keep survivors safe, there is a lack of formal policies regarding this issue. This included concerns about survivors and perpetrators separately receiving services from the same organization at the same location and concerns about couples counseling being provided when there is domestic violence.

We were both coming here for therapy and eventually I started telling them about the abuse... They told him he couldn't come because I was here, and then they let him come back. He has to come in because he was here first. It was real scary that they let him come back. – MH Service Recipient

The policy is that if there is domestic violence, then there is not going to be a referral to couples counseling. But if you don't know... - SMH Service Provider

Knowledge Implications:

Service recipients and providers agree that providers need more knowledge about survivors with mental health concerns. The responses to the online surveys indicate that 42% of mental health providers and 45% of domestic violence advocates have had only a little or no training about the other field's area of expertise. This points to need for an increase in training and an increase in consultation between the fields.

The significant percentage of mental health providers who reported having little or no training about domestic violence is not surprising considering that Washington State does not require it of them. The significant percentage of domestic violence advocates who have little or no training about mental health is not surprising considering the domestic violence movement's perception that the mental health system psychopathologizes survivors. This perception is grounded in the historical experiences of women in general and survivors in particular. Historically, claims of mental illness have been used to subjugate women.³ Many survivors have had their experiences devalued and their safety diminished by being labeled "crazy." While this is not currently acceptable to the vast majority of mental health providers, the psycho-pathologization of survivors unfortunately still persists by some mental health practitioners. As a result of abusive individuals and systems using allegations of poor mental health as a weapon to control survivors, some advocates are weary of addressing mental health concerns at all.

The responses to the online survey regarding consultation indicate that availability of consultation needs to be improved, that where consultation opportunities already exist then staff need to know about them, and that people need to be more aware of the benefits of seeking consultation.

Knowledge Recommendations:

1. Train Mental Health Providers

Mental health service providers responding to an online survey ranked these as the most important areas where they would like training:

- How to screen for domestic violence
- How to respond to domestic violence
- Safety planning
- Assessing lethality risk
- Cultural issues related to domestic violence and mental health

2. Train Domestic Violence Advocates

Domestic violence service providers responding to an online survey ranked these as the most important areas where they would like training:

- How to respond to mental health crises
- Understanding trauma-informed care
- Cultural issues related to domestic violence and mental health

³ For more about this see: [Women and Madness](#) by Phyllis Chesler. (1989)

- Understanding and navigating the local mental health system
 - Overview of mental health problems and treatments
3. Incorporate Training about Survivors with Mental Health Concerns into Staff Orientation
Knowledge of how to appropriately serve survivors with mental health concerns should be a prerequisite before staff start providing services.
 4. Provide Extensive Training for Staff on a Regular Basis
Skills and information about best practices should be kept current by regularly providing staff with in-depth training.
 5. Institutionalize Consultation
Develop mechanisms for making consultation routine and easy to obtain. Options could include developing reciprocal consultation agreements between providers or organizations, forming consultation groups, or contracting with consultants. Explore possibility of having consultation expectations for mental health providers that are similar to requirements for ethnic minority consultations. Training on how to best utilize and provide consultation should also be considered.
 6. Develop Policies Regarding Safety when Survivors & Abusers are Both Receiving Services
Organizations that serve both survivors and perpetrators of abuse need to enact mechanisms for maximizing survivor safety. Policies could specify that survivors and abusers will not receive services at the same location or at the same time. Policies regarding couples counseling should be strengthened or clarified, so that it is not an option for couples where there is domestic violence.

○○ Finding # 3C - Communication

Communication limitations within organizations and between organizations negatively impact both service providers and service recipients, but there are times when communication works very well.

Communication challenges were a theme that ran through many of the focus group responses at all of the organizations. When asked about challenges to improving services, about collaboration, and about ideas for changes, service providers repeatedly mentioned a lack of communication and information sharing as a key barrier to success.

It would be helpful to know how the mental health department operates. What's their approach? What are their goals? What can clients expect? – Consejo DV Advocate

It would be nice to be able to get through to an advocate when I have a client in the office. – SMH Service Provider

Ongoing relationships are really good. It's when you have to cold call that it doesn't really work. – SMH Service Provider

Communication between co-workers who are serving the same person came up repeatedly. Concerns about this were raised in the collaboration section, but it is worth noting here that lack of understanding about confidentiality limitations and practices, as well as a lack of clear referral protocols are highly related to internal communication issues. When concerns about how to best serve a client are not communicated and addressed, then this can escalate into negative perceptions and beliefs about one's co-workers.

Negative perceptions based on a lack of information was also a theme that came up repeatedly during the needs and strengths assessment. Negative attitudes about service recipients and providers often seemed to be based on misinformation, misperceptions, and sometimes a lack of general knowledge about the issue. For example, a service provider might develop a negative perception about another service provider or about the provider's field as a whole based on the belief that that the provider was willfully withholding important information. If that provider was not aware of the legal ramifications of the other provider releasing information about the service recipient, then their perceptions might be off base. If the person withholding the information was not able to clearly communicate why they could not share that information, then they may have been contributing to the problem.

Fortunately, service providers were also able to describe situations where strong communication has resulted in excellent service delivery. For example, New Beginnings transitional housing program staff described a mutually beneficial relationship with Ryther Child Center where strong communication has resulted in timely and effective service provision for children and their mothers.

Service providers also shared that participating in this project has already changed communication within their organizations for the better.

Right now because of this collaboration grant things are going so much better. We are working and talking and communicating. It's like we weren't even aware of it, but now that it's on the table, everyone is talking about it. – Consejo Manager

Communication Implications:

Since service recipients may only feel the need to mention their experiences with other providers when they have been difficult or harmful and not when they have been neutral or positive, providers may develop a skewed perception of the prevalence of problems with the other profession. Since a lack of communication can result in misinformation, misperceptions, negative attitudes towards each other and ultimately worse service for the client, it seems worthwhile and important for providers to take the time and effort necessary to clearly and respectfully communicate with each other. When service providers put aside their active listening, validation, and articulation skills in the interest of expediency they can actually do more harm than good.

Communication Recommendations:

1. Increase Opportunities for Communication & Connection

Examples of how to do this would include:

- Involve service providers from both fields in collectively addressing the recommendations in this report, so that they have opportunities to get interact and communicate with each other in a mutually beneficial and purposeful way.
- Hold quarterly informal gatherings
- Develop a case review process with partner organizations

2. Share Staff Contact Info

Partner organizations could put together staff rosters for other partner organizations to be able to use for consultation and referrals.

3. Clarify Organizational Structure and Feedback Processes

Agencies could share organizational charts, so other providers have a better understanding of how programs are organized and who staff report to within each organization. Agencies could discuss who should give and receive feedback to/from other agencies.

4. Designate Liaisons

Adapt job descriptions of relevant staff, so that they can serve as liaisons for the other partner organizations when they need assistance with accessing services or sharing information.

○○ Finding # 3D – Readiness for Change

Organizational leadership is ready for change and ways to facilitate successful change have been identified.

In response to questions on an online survey, board members reported that accessible and responsive services for survivors of domestic violence with mental health concerns are a high priority for themselves personally and for their organizations as a whole. They recognize their role in creating change, believe they have influence in making changes happen, and feel their organizations are adept at making change.

From the board of directors' online survey:

Our agency has an incredible history of being positioned to make changes nimbly, as needed.

Change tends to be a slow process, but we are willing to make changes that are needed to meet our mission.

We are committed to being a successful partner in this project.

Participants at the Appreciative Inquiry Summit were asked about their best experiences with facilitating and change and what they have learned about successfully facilitating change. Their responses included the following:

- *Support for change needs to be at all levels of the institution.*
- *Creating a collective voice for change helps determine a successful path.*
- *The absolute critical nature of “getting one’s own house in order” – our organization had to dramatically change internally to support change externally.*
- *The train is leaving the station.*

A service provider at a focus group at Seattle Counseling Service encouraged us to keep the big picture in mind when we are creating change. She talked about the complexity of the issues and the importance of addressing this work appropriately.

A danger in approaching domestic violence from a mental health perspective is that it will get reduced to being about interpersonal dynamics. Even if those dynamics are named as being about “power and control,” it can still be seen as power and control between two individuals, rather than being seen as a manifestation of much larger societal power dynamics around gender, race, class, sexual orientation, ability, and age. This also leads to a danger of seeing the solution as being merely therapeutic, such as, if we just work a survivor or a perpetrator on their mental health “issues,” then we will solve the problem of domestic violence. Unfortunately, mental health work and domestic violence work are often disconnected from social justice work.

Readiness for Change Implications:

All levels of each partner organization participated in this assessment and demonstrated their interest in and commitment to creating change. Board members, management, service providers, and service recipients all participated in this process and are ready for changes to be implemented. It is important to them that this process results in improvements to services for survivors with mental health concerns.

Readiness for Change Recommendations:

1. Have a Social Justice Analysis

Look beyond mental health and domestic violence services when addressing the needs of survivors with mental health concerns. Consider the societal implications of the problems and the solutions. Connect our efforts to the efforts of those working for social justice.

2. When working to implement changes keep in the mind the attributes identified at the Appreciative Inquiry Summit as important for facilitating change:

- Listen
- Provide Leadership
- Be Open
- Have a Positive Attitude
- Devote the Necessary Resources
- Allot the Necessary Time & Plan
- Recognize Culture & Diversity

○○○ Summary of Key Findings

Question # 1 – Who can get in?

This area of our findings addresses which survivors with mental health concerns are able to utilize services at our partner organizations.

Finding #1A - Capacity

Demands on the partner organizations are so high that it is extremely challenging for them to address the complex needs of survivors of domestic violence with mental health concerns. Funders enable providers to offer services, but some of their requirements and policies can inadvertently act as barriers to survivors getting their needs met.

Finding #1B – Accessibility

Each partner organization is strong in particular areas of accessibility, but they each have room for improvement in other areas of accessibility.

The lack of accessible and welcoming services in the community at large makes it much harder for service recipients to get their needs met, and puts more strain on the service providers who will help them.

The environment in which services are provided does make a difference.

Finding #1C - Screening & Assessment

A one size fits all approach to screening and assessment does not meet the needs of many service recipients.

Question # 2 – Do needs get met?

This area of our findings addresses what happens once a survivor with mental health concerns gains access to a service provider. Accessing services does not necessarily equate to getting one's needs met. Here we are asking if service recipients are getting their needs met regarding domestic violence and mental health.

Finding #2A- Service Quality

Service recipients want integrated, quality services that support them as a whole person. In order for services to be well integrated, referral processes need to be improved.

Services need to be strengthened in order to better meet the community's needs.

Finding #2B – Collaboration

Philosophical differences, trust and bias concerns, confusion about roles, and confidentiality and capacity issues can be barriers to collaboration between domestic violence and mental health service providers.

Question # 3– How can we do better?

This area acknowledges that we have room for improvement and addresses how we can create change. To address this question we identify:

Finding #3A – Sharing Strengths

Partner organizations each have valuable expertise and strengths that could benefit the other partner organizations.

Finding #3B – Knowledge

Service providers need more training, more consultation, and better policies in order to improve services for survivors of domestic violence with mental health concerns.

Finding #3C – Communication

Communication limitations within organizations and between organizations negatively impact both service providers and service recipients, but there are times when communication works very well.

Finding #3D - Readiness for Change

Organizational leadership is ready for change and ways to facilitate successful change have been identified.

○○○ Summary of Recommendations

Finding #1A - Capacity Recommendations:

1. Capacity Assessments

To better understand how much capacity is an issue, partner organizations could conduct capacity assessments. Assessing areas of capacity could assist organizations in determining what they are ready to do to improve services and what they need to work on in order to be able to make further changes, as well as sustain those changes.

2. Dialogue with Funders

It might also be helpful to discussing the findings from our needs and strengths assessment with key funders. Since funders and service providers tend to share the same goal of meeting the needs of service recipients, it could be helpful to engage funders in a dialogue about the impact of funding requirements on organizational capacity and on service quality.

Finding #1B - Accessibility Recommendations:

1. Provide Consultation

Each partner organization could provide consultation to the other partner organizations about the accessibility areas where they excel, so that each organization could improve their accessibility.

2. Eligibility Criteria

Each partner organization could provide the other partners with detailed information about eligibility criteria for their services and how people can access their services. This would enable organizations to provide their service recipients with accurate information about what services are accessible to them.

3. Attitudinal Accessibility

To improve attitudinal accessibility partner organizations could provide their staff with basic training about the diversity of survivors with mental health concerns and debunk some of the myths about them.

4. Accessibility Audits

Organizations could conduct accessibility audits focused on creating welcoming environments for survivors with mental health concerns.

Finding #1C - Screening & Assessment Recommendations:

1. Review Screening Practices at Domestic Violence Programs
Review screening practices at domestic violence programs to ensure that they are consistent, compliant with federal and state disability law, and utilize best practices.
2. Review Screening & Assessment Practices at Mental Health Program
Review screening and assessment practices at mental health programs to ensure that they are consistent and utilize best practices.
3. Develop Protocols for Ongoing Screening
Identify opportunities post-intake to inquire about the need for domestic violence and mental health assistance. This would enable people to be screened after they have developed rapport and trust with their service provider and prior to receiving couples counseling.
4. Train Staff on Responding to Screening & Assessment Disclosures
Staff could be given training on how to appropriately respond to disclosures of domestic violence and mental health concerns.

Finding #2A - Service Quality Recommendations:

1. Increase Co-Location of Services
Organizations should identify if it is possible for them to provide additional services at their current locations rather than referring people to other organizations at other locations to get their needs met. This could also mean that organizations have staff that travel to other locations to provide services.
2. Support Groups for Survivors with Mental Health Concerns
Organizations could offer support groups that are co-facilitated by domestic violence and mental health service providers that address the needs of survivors of domestic violence who have mental health concerns.
3. Improve Referrals
Protocols for improving referral processes could be developed. The expectation could be that service providers will directly connect service recipients with other providers whenever possible unless the service recipient does not want this assistance. Directly connecting a service recipient could involve calling the other provider together or physically going to the other provider's location together.
4. Use Liaisons
Partner organizations could identify staff to function as liaisons with the other partner organizations to assist providers in accessing services and making referrals.

5. Trauma Informed Care

Mental health organizations could assess if they are providing trauma informed care to their service recipients who have experienced domestic violence. Evidence-based treatment modalities should be made available to survivors.

Finding #2B - Collaboration Recommendations:

1. Address Information Sharing Practices

Review each program's release of information forms to determine if they are clear and appropriate for information sharing between professionals. Educate providers about the laws and best practices regarding confidentiality for mental health providers and confidentiality and privilege for domestic violence advocates. Encourage providers to involve the service recipient in all decisions about sharing of information and to participate in the calls or meetings between providers when appropriate.

2. Clarify Roles

Ensure that job descriptions are up to date and clear. Share information within and between organizations about the roles and responsibilities of each type of service provider. Educate providers about the philosophy of each profession and why each type of provider has their specific role.

Finding #3A - Sharing Strengths Recommendations:

1. Build on Strengths

Organizations could explore how they can sustain their areas of greatest strength and how they can further develop those strengths.

2. Provide Consultation

Each partner organization could provide consultation to the other partner organizations about the areas where they excel, so that each organization could improve their services.

Finding #3B - Knowledge Recommendations:

1. Train Mental Health Providers

Mental health service providers responding to an online survey ranked these as the most important areas where they would like training:

- How to screen for domestic violence
- How to respond to domestic violence
- Safety planning
- Assessing lethality risk
- Cultural issues related to domestic violence and mental health

2. **Train Domestic Violence Advocates**
Domestic violence service providers responding to an online survey ranked these as the most important areas where they would like training:
 - How to respond to mental health crises
 - Understanding trauma-informed care
 - Cultural issues related to domestic violence and mental health
 - Understanding and navigating the local mental health system
 - Overview of mental health problems and treatments
3. **Incorporate Training about Survivors with Mental Health Concerns into Staff Orientation**
Knowledge of how to appropriately serve survivors with mental health concerns should be a prerequisite before staff start providing services.
4. **Provide Extensive Training for Staff on a Regular Basis**
Skills and information about best practices should be kept current by regularly providing staff with in-depth training.
5. **Institutionalize Consultation**
Develop mechanisms for making consultation routine and easy to obtain. Options could include developing reciprocal consultation agreements between providers or organizations, forming consultation groups, or contracting with consultants. Explore possibility of having consultation expectations for mental health providers that are similar to requirements for ethnic minority consultations. Training on how to best utilize and provide consultation should also be considered.
6. **Develop Policies Regarding Safety when Survivors & Abusers are Both Receiving Services**
Organizations that serve both survivors and perpetrators of abuse need to enact mechanisms for maximizing survivor safety. Policies could specify that survivors and abusers will not receive services at the same location or at the same time. Policies regarding couples counseling should be strengthened or clarified, so that it is not an option for couples where there is domestic violence.

Finding #3C - Communication Recommendations:

1. **Increase Opportunities for Communication & Connection**
Examples of how to do this would include:
 - Involve service providers from both fields in collectively addressing the recommendations in this report, so that they have opportunities to get interact and communicate with each other in a mutually beneficial and purposeful way.
 - Hold quarterly informal gatherings
 - Develop a case review process with partner organizations

2. **Share Staff Contact Info**
Partner organizations could put together staff rosters for other partner organizations to be able to use for consultation and referrals.
3. **Clarify Organizational Structure and Feedback Processes**
Agencies could share organizational charts, so other providers have a better understanding of how programs are organized and who staff report to within each organization. Agencies could discuss who should give and receive feedback to/from other agencies.
4. **Designate Liaisons**
Adapt job descriptions of relevant staff, so that they can serve as liaisons for the other partner organizations when they need assistance with accessing services or sharing information.

Finding #3D - Readiness for Change Recommendations:

1. **Have a Social Justice Analysis**
Look beyond mental health and domestic violence services when addressing the needs of survivors with mental health concerns. Consider the societal implications of the problems and the solutions. Connect our efforts to the efforts of those working for social justice.
2. **When working to implement changes keep in the mind the attributes identified at the Appreciative Inquiry Summit as important for facilitating change:**
 - Listen
 - Provide Leadership
 - Be Open
 - Have a Positive Attitude
 - Devote the Necessary Resources
 - Allot the Necessary Time & Plan
 - Recognize Culture & Diversity

○○○ Conclusion and Next Steps

By conducting a detailed and thorough needs and strengths assessment, we were able to achieve our goals. We learned a great deal from service providers and recipients at our partner organizations about what is working well and where there is room for improvement regarding services for survivors of domestic violence with mental health concerns. Service recipients gave us a good picture of accessibility, service quality, and cultural competency at our partner organizations that provide direct services. Service providers gave us a good picture of the factors that contribute to their ability to provide quality services to domestic violence survivors with mental health concerns, as well as their barriers to do that well. We also were able to learn about the opportunities for change that exist in our organizations.

Throughout the process of doing this assessment, participants repeatedly asked what would happen with the information they were providing and if the process would really result in change. We will honor them and their input by responding to the recommendations in this report. Our next step will be to conduct a strategic planning process to determine which of these recommendations we will be implementing, the priorities for implementing them, and how they will be implemented. We will share our plans with the partner organizations.

Every process has its first step and its next steps and as one of the participants in our Appreciative Inquiry Summit wisely, said:

It has to begin with me. Oh damn, not again.

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○○○ Questions ?

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