

Violence against Women with Mental Illness



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Violence against Women with Mental Illness

WOMEN WITH MENTAL ILLNESS ARE SIGNIFICANTLY MORE LIKELY TO BE

victims of violent crime than other women. Mental health service providers, victim advocates, and other policymakers and practitioners generally know little about women with mental illness who have experienced violence. Furthermore, state and local government officials and advocates have few, if any, resources available to them—resources that can be tapped to help protect, inform, serve, and treat this population and minimize the likelihood that they are victimized again.

This issue brief addresses the following questions:

- I. What do we know about women with mental illness' vulnerability to violent crime?^{1,2}
- II. What challenges confront victim advocates, mental health service providers, and justice officials attempting to serve women with mental illness who have been victims of crime?
- III. What programs have attempted to serve effectively women with mental illness who are victims of crime?
- IV. What resources are available to the field?
- V. Where do we go from here?

The Pennsylvania Department of Corrections defines "serious mental illness" as: "a substantial disorder of thought or mood which significantly impairs judgment, behavior, and capacity to recognize reality or cope with the ordinary demands of life." The term "serious mental illness," however, is subject to numerous definitions by corrections and mental health departments across the country and even within the same jurisdictions.

1 The Center for Mental Health Services has supported projects that address violence against all men, women, and children. This project specifically addresses the needs of women, as called for in the President's New Freedom Commission on Mental Health. No funding is currently available.

2 This issue brief contemplates women with severe or serious mental illness who are

victims of crime. Individuals with symptoms associated with brain injury, mental illness related to aging (e.g. dementia), co-existing developmental disability, and co-occurring substance abuse disorder *are* included in the target population of this issue brief. The target population excludes individuals with symptoms of character disorder, developmental disability, or substance abuse disorder *exclusively*.

Mental illness and victimization are frequently linked, and it is often difficult to determine the sequence of this dynamic relationship. This issue brief does not address the many women in need of counseling or support because of trauma associated with victimization, but instead focuses on women with an ongoing mental illness and for whom victimization has recently been determined/experienced.

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I.

What do we know about women with mental illness' vulnerability to violent crime?

Little research exists that focuses exclusively on the relationship between victimization and mental illness in women. Consequently, rates of victimization for this population have not been established and knowledge of the risk factors for victimization is limited. Instead, policymakers are forced to piece together an incomplete picture from studies of different groups of victims.

Existing research focuses on the following groupings of subjects: people with mental illness living in the community and in psychiatric inpatient settings; people who are homeless; and people with crime-related mental illness. Taken collectively, these studies point to disproportionately high rates of victimization among women with mental illness and suggest explanations for why women with mental illness are at higher risk for victimization.

A. People with mental illness, regardless of gender, are more likely to be the victims of violent crime than the general population.

Violent victimization of people with mental illness occurs at a higher rate than victimization in the general population (two and a half times more often).³ Multiple studies of crime against psychiatric inpatients and people with schizophrenia are consistent with this finding.⁴ A number of explanations have been offered for the increased rate

of victimization among people with mental illness: These individuals may have difficulty protecting themselves, thereby increasing their vulnerability to victimization. Individuals with mental illness often live in less affluent neighborhoods in which crime rates are high.⁵ The significant chance that law enforcement or other officials may not believe the claims of people with mental illness may leave them vulnerable to additional victimization.

B. Among people who are homeless, mental illness is a serious risk factor for victimization.

People who are homeless and have a mental illness are at high risk for victimization,⁶ with homeless women being victimized at a rate slightly higher than the rate at which homeless men are victimized (49.4 percent versus 41.3 percent).^{7,8} Women who are homeless and have a mental illness may experience increased victimization for a variety of reasons: depression and related mental health disorders may make them less likely to leave abusive relationships,⁹ and those who have been victimized and suffer from depression may be placed in riskier situations or find themselves in unprotected conditions that result in continued victimization.¹⁰ More research is needed to determine the degree to which these findings are applicable to all women with mental illness.

3 Hiday et al., 1999.

4 Brekke et al., 2001: A sample of people with schizophrenia living in an urban area found both overall and violent victimization rates to be two times higher than for the general population (12–17 percent versus 7 percent). In France, twice as many women with schizophrenia or bipolar diagnosis reported being raped versus the general population (15 percent versus 8 percent).

In another study, 81 percent of psychiatric inpatients, both male and female, reported experiencing serious physical and/or sexual assault (Jacobson and Richardson, 1987).

Another study found that 50–70 percent of female psychiatric inpatients had histories of physical or sexual abuse (Jennings, 2004).

5 Teplin, 1996.

6 Nyamathi et al., 2001.

7 Lam and Rosenheck, 1998.

8 Major depression was significantly associated with physical and sexual victimization in a study of 311 sheltered homeless women (Nyamathi et al., 2001). Homeless women with mental illness report high rates of victimization, with 30 percent reporting physical assault while homeless and 34 percent reporting sexual assault (Treatment Advocacy Center, 2003).

9 Nyamathi et al., 2001.

10 *Ibid.*

C. Mental illness may result from crime-related victimization.

The term “crime-related mental illness” refers to mental disorders that are a direct result of criminal victimization. Studies of crime-related mental illness focus primarily on depression and Post Traumatic Stress Disorder (PTSD), two of the common mental illnesses related to victimization.¹¹ PTSD, in particular, often co-occurs with other types of mental illness.¹²

Women who are victims of violence suffer from mental illness at a higher rate than women who have not been victimized. Female victims of domestic violence are five times more likely to attempt suicide than women who are not domestic violence victims and three times more likely to be diagnosed as depressed or psychotic.¹³ Women with mental illness often have histories of violence or victimization. Almost one-third of women in psychiatric

inpatient and outpatient settings have been exposed to domestic violence situations where they are battered¹⁴ and chronic mental illness has been found to be a risk factor for some types of intimate partner violence against women.¹⁵

For all categories of victims, victimization and mental illness are related, although it is often difficult to determine whether the emergence of mental illness (or its intensification) pre- or post-dates the victimization. But countless studies confirm that the best predictor of future victimization is past victimization,¹⁶ and this chronic victimization, in turn, is found to contribute to higher levels of serious mental illness.¹⁷ Past victimization can also be a risk factor for future crime-related mental illness. For example, individuals with a history of victimization suffer more crime-related psychological trauma than those with no prior victimization,¹⁸ and prior victimization has been found to increase the likelihood of psychological trauma following a new crime.¹⁹

¹¹ PTSD is an anxiety disorder that is the result of exposure to one or more traumatic events. According to *DSM-IV*, the following criteria must be met: the person has experienced a traumatic event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and the person's response involved intense fear, helplessness, or horror; the traumatic event is re-experienced in specific ways such as recurrent and intrusive distressing recollections or dreams of the event; persistent avoidance of stimuli associated with the trauma or

numbing of general responsiveness; persistent symptoms of increased arousal, such as hypervigilance or irritability; duration of the disturbance is more than one month; the disturbance causes clinically significant distress or impairment in functioning.

¹² People who develop PTSD as a result of a trauma are two to four times more likely to have an additional psychiatric diagnosis than trauma victims that do not develop PTSD (Missouri Institute of Mental Health, 2002). Seventy-nine percent of women with PTSD have a lifetime prevalence of other

psychological problems. The chance of presenting with major depression is increased in individuals who develop PTSD. (Kilpatrick and Acierno, 2003)

¹³ Salasin and Rich, 1993.

¹⁴ *Ibid.*

¹⁵ Coker et al., 2002.

¹⁶ Kilpatrick and Acierno, 2003.

¹⁷ U.S. Department of Justice, 1998.

¹⁸ *Ibid.*

¹⁹ U.S. Department of Justice Web site, *The Mental Health Impact of Crime*.

II.

What challenges confront victim advocates, mental health service providers, and justice officials attempting to serve women with mental illness who have been victims of crime?

A. Mental health providers typically do not know—and do not obtain information that would help them determine—when a client they are serving has recently been the victim of a crime (or has a history of victimization).

In general, all victims of crime, including women with mental illness, underreport their victimization and mental illness. In 2000, only half of violent crime and 39 percent of all crime was reported to police.²⁰ The reasons for this underreporting are varied. Many victims believe that their victimization is a personal or private matter and choose not to share it with law enforcement, health, or mental health professionals.²¹ Poorly enforced witness protection provisions, such as restraining orders or the prosecution of witness tampering, lead to fear of retaliation from the perpetrator.²² Cultural, linguistic, and physical barriers can prevent access to assistance for some victims while immigrants who fear deportation may not trust the justice system. Some victims view the criminal justice proceedings themselves as traumatic—the “re-victimization” that happens when victims enter into formal legal proceedings can serve as a powerful deterrent to reporting.²³ Feelings of shame and guilt over being a victim can also inhibit people from reporting a crime or seeking help.²⁴

Underreporting of victimization is especially common among people with mental illness, partly because health and mental health professionals often do not inquire about abuse. Standard procedures for routine inquiry about crime and victimiza-

tion are uncommon. Mental health professionals tend to treat presenting problems without exploring underlying causes.²⁵ Furthermore, mental health providers typically lack the training necessary to respond appropriately to the disclosure of victimization. To complicate matters further, it is common for someone with untreated mental illness to fail to recognize past abuse as victimization (but this dynamic is hardly unique to people with mental illness).²⁶

B. People working in the criminal justice system typically do not know—and do not obtain information that would help them determine—when a victim they are serving has a mental illness.

People working in the criminal justice system—whether in law enforcement or as a victim service provider—typically have little or no training around mental health issues. They do not know how to spot signs of mental illness and are not expected to ask questions to screen for mental illness. Furthermore, recognizing signs of mental illness among women who are victims of crime is especially difficult because they are unlikely to exhibit symptoms most commonly expected of someone with untreated mental illness (e.g. hearing voices, suicidal tendencies).

In this environment, it is unlikely that women will disclose any history of mental health treatment. It is even more unrealistic to expect staff to identify the possibility of a mental illness when the woman herself has yet to recognize it.

20 U.S. Department of Justice, 2003.

21 *Ibid.*

22 Herman, 2003.

23 *Ibid.*

24 Salasin and Rich, 2003.

25 In one study, mental health professionals failed to inquire about a history of abuse in

all of their 89 intensive case management clients. Of those who disclosed abuse, only three received responses, none of which adequately addressed the issue to the satisfaction of the client. This study found widespread neglect of routine inquiry into abuse history, exclusive treatment of secondary characteristics, and over-diagnosis of abuse victims with borderline personality disorders (Rose et al., 1991).

In a separate study of 394 women seen in a family practice clinic, a large minority had been assaulted by partners within last year or had endured lifetime abuse, but the treating physician had inquired about domestic violence in only one percent—or four—of the cases (U.S. Department of Justice, 2000).

26 Hiday et al., 1999.

C. Perceptions among people working in the criminal justice system about the credibility or reliability of crime victims with mental illness can discourage appropriate follow-up.

The public frequently stereotypes people with mental illness as being inclined to violence. Law enforcement officers, prosecutors, judges, and other criminal justice officials are vulnerable to similar misconceptions, even though extensive research has consistently contradicted these beliefs. A survey of police officers in Chicago revealed that police still treat people with mental illness differently than they treat others.²⁷ Another study found that people with mental illness seeking assistance for domestic violence are often referred to psychiatric inpatient or outpatient treatment—their report of a crime is viewed as part of their mental illness.²⁸

These stereotypes can deter victims with mental illness from seeking appropriate assistance or even from reporting their victimization. These beliefs may place people with mental illness at a higher risk for victimization, as their abusers are aware of the reduced likelihood that their victims will be believed if they do report a crime.²⁹

D. The absence of a clear and accurate understanding of laws and regulations regarding the confidentiality of mental health

information and mandatory reporting impedes the appropriate exchange of information between mental health and justice systems.

Mental health providers and criminal justice officials often cite laws that protect the confidentiality of mental health information and that mandate reporting of abuse as factors that impede information sharing between the mental health and criminal justice systems. State laws protect the confidentiality of mental health sessions to varying degrees, from absolute privilege to qualified privilege with disclosure allowed under specific circumstances. For example, victims that are counseled by unlicensed psychologists or psychotherapists often receive no testimonial privilege for their counseling session. In some cases, counseling records can be disclosed in court, despite the protests of the victim. Like mental health records, medical records are not always adequately protected in court.

At the individual level, spouses, insurance companies, employers, and law enforcement officials may use legal proceedings to gain access to medical records, which can deter victims from seeking help from the justice system. In some cases, mandatory reporting laws, designed to help victims, may deter those who are unwilling to report their victimization from seeking medical or mental health assistance.³⁰

²⁷ Despite feeling compassionate toward someone identified as mentally ill, many police officers indicated that they would not consider that person credible in reporting criminal victimization, would be less likely to register

a complaint by this person against a neighbor, and would be less likely to follow up on his or her testimony as a witness (Resource Center to Address Discrimination and Stigma, 2004).

²⁸ SafePlace, 2002.

²⁹ Kilpatrick and Acierno, 2003.

³⁰ U.S. Department of Justice, 1998.

E.
There is a high rate of co-occurring substance abuse disorders among women with mental illness who are crime victims.

According to the 2002 *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse and Mental Health Disorders*, about 15 percent of adults with a diagnosable mental disorder have a co-occurring substance abuse disorder during any 12-month period.³¹ It is not uncommon for people with untreated mental illness to use illicit drugs as a form of self-medication. In some cases, abusing substances is also a way for women to distance themselves from past and current victimization. Ultimately, substance abuse can mask mental illness and hide victimization, leaving both issues untreated.

Treatment for individuals with co-occurring mental health and substance abuse disorders should be delivered in an integrated manner, where both disorders are considered primary.³² Unfortunately, neither the mental health system nor the criminal justice system has begun to fully integrate substance abuse treatment into their response protocols. To further complicate the response to crime victims with co-occurring mental health and substance abuse disorders, there is a misperception by many mental health and criminal justice providers that an individual who buys and uses drugs cannot also be a victim of crime.

³¹ Substance Abuse and Mental Health Services Administration Web site, Report to Congress.

³² Substance Abuse and Mental Health Services Administration, Women, Co-occurring Disorders and Violence Study.

III.

What programs have attempted to serve effectively women with mental illness who are victims of crime?

A number of service providers across the country—some working from the perspective of a victim advocate and others from the perspective of a mental health service provider—have developed programs and policies designed to meet the distinct needs of women with mental illness who are victims of crime. Little or no empirical evidence is available to confirm the impact of these efforts, but they are useful case studies for policymakers and other practitioners seeking examples of conceptual approaches used by programs to protect and serve this population.

The strategies used by the sexual assault, domestic violence, and mental health service providers below fall into two categories of service delivery:

- The provider identifies the treatment and service needs, refers the individual to appropriate services, and provides linkages to those services.
- The provider identifies the treatment and service needs and provides the necessary treatment and services in-house.

A. Identify, Refer, and Link

1. [Harborview Medical Center, Center for Sexual Assault and Traumatic Stress \(formerly Harborview Sexual Assault Center\), Seattle, WA](#)

The Harborview Medical Center, Center for Sexual Assault and Traumatic Stress, serves people affected by sexual assault and other traumatic events. The hospital serves as the county's central service for emergency sexual assault care and also has a community mental health center and inpatient psychiatric unit. Sexual assault services are culturally sensitive to the needs of this population of victims.

A victim of sexual assault who requests medical or counseling care is seen by a social worker at intake. The social worker assesses past mental health

history and current mental health needs during this initial contact. If the social worker determines that the person may have a mental illness, he or she investigates whether there is any history of involvement with the mental health system. If the person is actively involved in the mental health system, the social worker seeks the victim's permission to coordinate their case management with the mental health provider. If no match is found, the social worker takes steps to connect the victim to a mental health service provider.

When a social worker sees an individual who has a mental illness, he or she adjusts the trauma therapy accordingly. For example, being raped may put a person with mental illness at risk for decompensation, so rather than immediately beginning trauma-focused therapy, staff may focus on stabilizing the individual with appropriate medications and making sure the individual feels safe.

Harborview's staff recognizes that one of the keys to their success is their close relationship with the local police department and prosecutor's office, and the sensitivity of these departments to the needs of this population of crime victims. Specifically, these departments recognize the importance of obtaining the cooperation of female crime victims with mental illness during their criminal investigation and that these individuals are particularly vulnerable to criminal victimization.

2. [SafePlace, Austin, TX](#)

SafePlace provides shelter to women, children, and men who have been sexually assaulted or victims of domestic violence. While other shelters with a similar mission may screen out clients who present symptoms of a mental illness, SafePlace has taken steps to incorporate this population into its clientele. Administrators of the organization have developed a training manual for staff that highlights common signs of mental illness in a victim and what to do if these signs are present.

People admitted to the shelter are screened for various needs and services. When an advocate/case worker conducting this screening determines that a person may have a mental illness, he or she is referred to a community mental health provider. People who are actively psychotic or decompensating are referred to a state mental health hospital. These victims are referred back to SafePlace once they are stabilized.

B. **Identify and Treat**

Community Connections, Washington, D.C.

Community Connections is a private, nonprofit mental health agency in Washington, D.C., that provides clinical programs, residential services, and supportive services to marginalized populations, including women with mental illness who have been victims of domestic violence and sexual assault. Two programs, Project Hope and the Women's Trauma Project, both identify and treat women with mental illness, current or past histories of domestic violence, and/or sexual assault.

Project Hope targets girls from ages 12 to 18 in D.C. public and charter schools. Project Hope aims to 1) increase the understanding of trauma, its impact, and the recovery process among youth, parents, school staff, and clinicians; 2) facilitate the identification of girls with histories of violent victimization and provide treatment in Community Connections mental health services; 3) minimize barriers for girls to participate in services; 4) reduce the possibility of inadvertent re-traumatization of survivors by the educational and human service systems; and 5) train DMH clinicians working in schools to use a time-limited, manualized group intervention for adolescent girls with histories of violent victimization.

The Women's Trauma Project targets women who have experienced trauma and abuse either in childhood or adulthood. The women in this program receive a full range of clinical services, individual and group therapy, psychiatric care, and residential support services.

IV. What resources are available to the field?

People seeking to improve their organizations' responses to women with mental illness who have been the victims of crime can tap into a variety of resources that provide information, training, technical assistance, and funding support. The following are a sample of federal and nonprofit resources.

A. Substance Abuse and Mental Health Services Administration (SAMHSA)

1. [Center for Mental Health Services \(CMHS\)
National Center on Trauma Informed Care](#)

SAMHSA, a division of the U.S. Department of Health and Human Services, launched the *Women, Co-Occurring Disorders and Violence Study (WCDV)*, available at <http://www.prainc.com/wcdvs/publications/default.asp> in 1998 to respond to the complex needs of women with co-occurring substance abuse and mental health disorders. The project developed an integrated services approach for women with co-occurring disorders who have histories of violence, applied the model in sites across the country, and evaluated the model's effectiveness. This landmark study demonstrated that integrated, consumer-informed services can play a key role in recovery.

Based on the knowledge gained through the WCDV study, SAMHSA has now launched CMHS's National Center for Trauma Informed Care (available at <http://mentalhealth.samhsa.gov/nctic/>) to help states and communities become "trauma-informed." The center is designed to assist trauma survivors within the contexts in which they live and work, and will focus on five priority populations:

- Women and adolescents with co-occurring mental health and substance abuse problems and histories of violence,
- Women trauma survivors in the criminal justice system and women crime victims,
- Refugee and immigrant women,

- Men with histories of trauma, and
- Consumer-survivor leadership.

2. [Center for Mental Health Services Block Grant](#)

Administered by the Center for Mental Health Services (CMHS), a branch of SAMHSA, the CMHS Block Grant gives funding to states to provide mental health services to people with mental illness. The program was authorized by the Public Health Service Act and serves as the largest federal source of support for improving mental health services nationwide. The program supports existing public mental health services and seeks to develop new, cost-effective, community-based care models for people with mental illness. For more information, visit <http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0022/>.

B. Office of Violence Against Women (OVW)

OVW, a division of the U.S. Department of Justice, administers a grant program that funds training for efforts to improve the understanding of, and response to, women who are victims of crime and have a mental illness.

1. [Education, Training and Enhanced Services to End Violence Against and Abuse of Women with Disabilities](#)

Created by the Violence Against Women Act of 2005, this discretionary grant program is designed to provide training, consultation, and information on domestic violence, dating violence, stalking, and sexual assault against individuals with disabilities, which includes mental illness, and to provide direct services to such individuals. Congress, OVW, and victim advocates recognized the need to focus on domestic violence, dating violence, stalking and sexual assault against individuals with disabilities due to the proliferation of such violence and the gaps in service provision and the criminal justice response

for this population. The goal of this program is to build the capacity of such jurisdictions to address such violence against individuals with disabilities through the creation of multi-disciplinary teams. For more information, visit <http://www.usdoj.gov/ovw/ovwgrantprograms.htm>.

C. Office for Victims of Crime (OVC)

OVC, a division of the Office of Justice Programs in the U.S. Department of Justice, administers training, compensation, and assistance programs for victims of crime, including women with mental illness.

1. Training and Technical Assistance Center (TTAC)

The TTAC provides training services to improve victim assistance across many disciplines, focusing on victim services providers, advocates, law enforcement officials, and officials in other areas of the criminal justice system. The goal of TTAC is to support the development of victim services by increasing the availability of skilled, capable, and sensitive assistance for victims of crime. For more information, visit <http://www.ojp.usdoj.gov/ovc/assist/welcome.html>.

2. State Victim Compensation Programs

OVC administers formula grant funding for state victim compensation programs that reimburse crime victims for crime-related expenses, such as medical costs, mental health counseling, funeral and burial costs, and lost wages. Each state administers its program independently, but most programs have similar eligibility requirements and offer similar benefits. The limits on mental health counseling benefits can vary based on number of session, dollars spent, or time in treatment. For more information, visit <http://www.ojp.usdoj.gov/ovc/help/links.htm>.

3. State Victim Assistance Programs

OVC also administers formula grant funding for state victim assistance programs to fund community-based organizations that serve crime victims. Eligible organizations include domestic violence shelters, rape crisis centers, child abuse treatment programs, and victim services units in criminal justice agencies and hospitals. Services provided under these programs include crisis intervention, counseling, emergency shelter, criminal justice advocacy, and emergency transportation. For more information, visit <http://www.ojp.usdoj.gov/ovc/help/links.htm>.

4. Victims of Crime Act Discretionary Grant Programs

Authorized by the Victims of Crime Act (VOCA), OVC's discretionary grants program seeks to improve and enhance the quality and availability of victim services. Eligible applicants include states, local units of government, individuals, educational institutions, private nonprofit organizations, and private commercial organizations. OVC modifies its priorities annually, based on changing issues in the field of victim services. For more information, visit <http://www.ojp.usdoj.gov/ovc/fund/welcome.html#dg>.

D. National Crime Victims Research and Treatment Center (NCVC)

NCVC seeks to achieve a better understanding of the impact of criminal victimization on adults, children, and their families. As part of the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina in Charleston, NCVC provides specialized clinical services to adult and child victims of violent crime and their families. NCVC provides continuing education to mental health professionals and those in the fields of criminal victimization and child abuse. They also consult

legislators, public policymakers, and program administrators who are interested in their research findings and clinical expertise. For more information, visit <http://www.musc.edu/cvc/>.

E.
The National Trauma Consortium (NTC)

The purpose of the National Trauma Consortium is to raise public awareness about the prevalence of trauma and its wide-ranging impact on people's lives. The primary goals of NTC are to 1) strengthen the interaction of research and practice by developing, evaluating, and refining new and existing service models; 2) increase the impact of research through activities in the public arena, including advocacy, public policy, and public education and awareness; and 3) enhance the capacity of individuals and organizations to plan, implement, and oversee effective service approaches by offering high quality training and technical assistance, including leadership development. For more information, visit <http://www.nationaltraumaconsortium.org>.

F.
Trauma Knowledge Utilization Project (TKUP)

The Trauma Knowledge Utilization Project's mission is to include trauma survivors at the core of all systems change activities, from policy and financing to training and services. To date, TKUP's efforts include coordination of conferences, presentations, and retreats to support the inclusion of trauma survivors in policy and program development. A Web site is currently being developed, but to learn more about TKUP, visit the National Trauma Consortium's Web site provided above.

G.
National Coalition Against Domestic Violence (NCADV)

The National Coalition Against Domestic Violence's mission is to work toward eliminating both personal and societal violence against women and children. NCADV's work includes coalition building; public education and technical assistance; development of innovative policy and legislation; support for community-based, non-violent alternatives for battered women and their children; development of caucuses and task forces to represent the concerns of underrepresented groups; and support for efforts to end social conditions which contribute to violence against women and children. For more information, visit <http://www.ncadv.org>.

V. Where do we go from here?

Existing research, while sparse and often inconsistent, suggests that women with mental illness are at risk of victimization and need interventions tailored to their unique needs. But the rates and risk factors of victimization for this population have not been sufficiently documented, and services that appropriately address the needs of this population have not been identified. The following recommendations are designed to increase understanding of women with mental illness who are victims of crime and suggest ways that they can be best served to prevent future victimization.

A. Research

Researchers who study both mental illness and criminal victimization should view women with mental illness who are victims of crime as a unique population. Dedicated research efforts are needed to understand the problem of victimization of women with mental illness, and help establish best practices for serving this population in order to prevent future victimization. Researchers should consider the following questions: What is the prevalence of victimization of women with mental illness living in community settings? What are the risk factors for this victimization? What are the unique needs facing women with mental illness who have been victimized? What services and interventions help these women recover from their victimization? What steps can be taken to prevent their future victimization?

B. Program and Policy Development

At the same time that a research base is developing, service providers and advocates need information about innovative programs and strategies in order to identify and respond to the needs of this population. Program strategies must cover a range of services, including health and mental health

services, crisis counseling, trauma education and counseling, interaction with law enforcement, and participation in legal proceedings. To stimulate and promote innovation, policymakers should disseminate information about promising programs and policies. This information should include descriptions of creative funding strategies, which maximize the use of existing resources to finance programs and policies.

C. Education and Training

1. Education

Policymakers should increase awareness among criminal justice practitioners and advocates about the prevalence of mental illness among women who are victims of crime; similarly, mental health providers and members of the mental health consumer movement must begin to appreciate the significance of victimization among women with mental illness. Higher education programs for social work, nursing, and medicine should also require training on working with victims with mental illness. In all cases, education for practitioners needs to include efforts to dispel misperceptions about victimization and mental illness. To these ends, information about these issues should be integrated into existing conferences, newsletters, and Web sites that target these constituency groups.

2. Training and Technical Assistance

Once there is increased appreciation among professionals in the criminal justice and mental health systems about these issues, they must take advantage of training and technical assistance opportunities regarding working with women with mental illness who have experienced victimization.

3. Cross-Training

Sparking innovation and systemic change will ultimately depend on the extent to which professionals

serving victimized women with mental illness appreciate and understand how the mental health and criminal justice systems work. Accordingly, policymakers should facilitate cross-training opportunities in individual jurisdictions, which would enable staff and leaders in mental health and criminal justice systems to meet and educate each other. These cross-training opportunities might also lend themselves to the development of a shared vocabulary between criminal justice and mental health agencies. In addition, policymakers and program administrators should encourage inter-agency coordination (e.g. the Coordinated Community Response Model) to develop a shared understanding and response to this population of crime victims.

As this document demonstrates, the victimization of women with mental illness is an important issue with major implications for the safety and health of a significant number of women who are currently in contact with the criminal justice and mental health systems. While the challenge of addressing the needs of this population is significant, there are existing programs that provide promising examples of effective treatment interventions and existing resources that can be tapped to support such programs. The next step should be to develop a comprehensive strategy around research, program development, and training to improve services for women with mental illness who are victims of crime.

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