



Working with Brain Injuries and Mental Health in Domestic Violence Programs

Findings from the Field



About this Report

This document, *Working with Brain Injury and Mental Health in Domestic Violence Programs: Findings From the Field* details lessons learned through the needs assessment and over the course of the project. The goal of sharing findings from the field is for others interested in increasing access to learn from our success, challenges, and insights. ODVN developed two additional documents as a part of this project. *Working with Brain Injury and Mental Health in Domestic Violence Programs: An Action Plan to Improve Access and Attitude Changes in Ohio* discusses the activities, results, recommendations, and next steps of the three year project. *Working with Brain Injury and Mental Health in Domestic Violence Programs: Project Evaluation* provides more detailed information on project approach, research design, and results.

About ODVN

The Ohio Domestic Violence Network (ODVN) is a 501(c)3 not-for-profit agency located in Columbus Ohio. ODVN is a statewide domestic violence agency that supports and strengthens Ohio's response to domestic violence through training, public awareness and technical assistance and promotes social change through the implementation of public policy. ODVN's primary audience for trainings and technical assistance are local domestic violence and crime victim service agencies throughout Ohio.

Acknowledgement of Programs

ODVN is forever indebted to the heroes of domestic violence advocacy—staff at domestic violence programs. Deepest thanks for their genuine partnership on this endeavor. The Founding CARE Programs include:

Artemis Center (Dayton) • Eve, Inc. (Marietta) • Harbor House (New Philadelphia)
House of Ruth (Defiance) • Turning Point (Marion and Delaware)

ODVN would also like to thank our Community of Practice partners that so generously dedicated their time, energy, expertise, and passion to this work.

INTRODUCTION

Domestic violence programs provide safety, support, and life-saving services. It is critically important that all domestic violence survivors, including those with disabilities, can access and benefit from program services. In recognition of the importance of addressing mental health and brain injury disabilities, the Office on Victims of Crime Vision 21 Initiative selected ODVN as one of two coalitions in the United States to implement this work through OVC FY 2016 Enhancing Access and Attitudinal Changes in Domestic Violence Shelters for Individuals With Disabilities (2016-XV-GX-K012). ODVN used two strategies for this project: equipping local DV program staff to accommodate the needs of survivors and building collaboration with agencies and organizations that work with mental health and brain injury to increase access to services.

Due to the requirements of the project, ODVN, in collaboration with research partner The Ohio State University, pursued Institutional Review Board (IRB) approval from The Ohio State University to oversee the research and evaluation of this grant. This allows ODVN to share these findings from the field that has the potential to transform crime victim services.

The findings from this groundbreaking project are significant, and many. These lessons learned can help statewide organizations implement capacity building projects, and/or guide local programs in a variety of professions interested in better addressing mental health and brain injury in their services.

Findings are grouped into two categories:

- Lessons learned about the intersection of domestic violence, brain injury, and mental health.
- Findings on effectively addressing brain injury and mental health in domestic violence services.

The findings from this groundbreaking project are *significant, and many.*

LESSONS LEARNED ABOUT BRAIN INJURY AND MENTAL HEALTH

- 1** Almost all domestic violence survivors experience violence that could cause brain injuries and many struggle with mental health.
- 2** Domestic violence causes and exacerbates brain injury and mental health struggles, and is connected to suicidality and substance use.
- 3** The field knows domestic violence impacts mental health. But programs struggle with effectively providing services and meeting the needs of survivors with mental illness, especially with the lack of available and accessible of trauma-informed mental health services.
- 4** The field doesn't know that domestic violence victims might have brain injuries. While domestic violence victims report incredibly high levels of head trauma, brain injury is largely unidentified, rarely addressed, and not well understood by domestic violence programs.
- 5** Brain injury in the context of domestic violence (termed partner inflicted brain injury) is **markedly different** from other commonly studied brain injuries, including brain injuries caused by accidents, sports, and combat.

Please Note:

Unless otherwise noted, all data gathered in this report comes from:
JM Nemeth, PhD., unpublished data: CARE Process & Outcome Evaluation 2019 or Ohio Domestic Violence Network, unpublished data: CARE Training Evaluations, 2018.

Lesson 1: Almost all domestic violence survivors experience violence that could cause brain injuries and many struggle with mental health. DV programs should assume that victims accessing services are struggling with their emotional well-being and have been hurt in ways that could cause brain injury until proven otherwise.

Through research conducted as a part of this project, ODVN learned that domestic violence victims have lived through extensive violence directed at the head, neck and face and through strangulation. They have also experienced emotional abuse, mental health coercion, and live in traumatic environments.

The alarming and disturbing statistics speak for themselves. When talking with domestic violence survivors participating in domestic violence services over 90% of survivors agreed or strongly agreed with the statement, “It is common for someone accessing this agency to struggle with mental health.”

The research on domestic violence and traumatic brain injury is scarce, and ODVN is making a major contribution to this area of work through the research conducted as a part of this grant. It has provided some of the earliest glimpses into the prevalence, frequency, and experience of partner inflicted brain injury (including traumatic brain injury and strangulation) experienced by survivors. In terms of hits or blows to the head, **85%** of domestic violence victims accessing domestic violence program services at five local domestic violence partner agencies **have been hit in the head**, with almost **50%** of survivors reporting that their head was hurt too many times for them to count. Close to **83%** of survivors interviewed were strangled, and of those **88%** of survivors said it happened a few times or too many times to count.

85% experienced blows to the head

of those

50% experienced it too many times to count

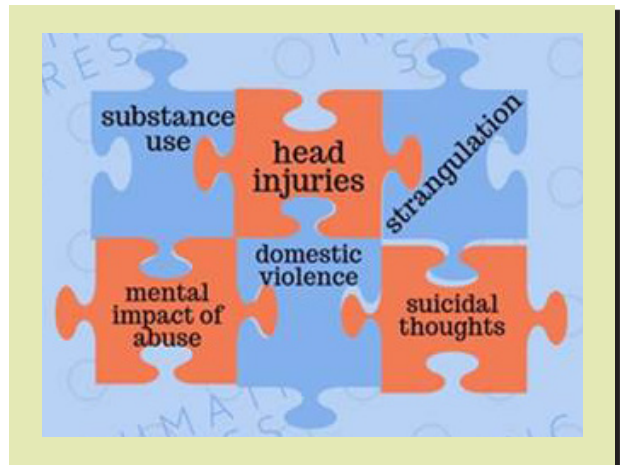
83% experienced strangulation

of those

88% experienced it multiple times

Lesson 2: Domestic violence causes and exacerbates brain injury and mental health struggles, and is connected to suicidality and substance use. These public health problems, on both an individual and population level, are intertwined and very much related to the traumatic impact of abuse.

Brain injury, mental health, suicide, and substance use are unique public health challenges with their own characteristics, responses, and approaches. But due to their significant overlap, domestic violence programs must use a holistic framework and understanding of how these issues are integrated. While brain injury is a newer topic for domestic violence advocates, ODVN intentionally resisted separating and addressing them in isolation. A very stark example is how an experience of strangulation—that could cause a brain injury—can also cause PTSD or trauma reactions such as flashbacks, avoidance reactions, or withdrawal. Domestic violence can also exacerbate any existing mental health challenges.



Research funded by this project, conducted by ODVN in collaboration with The Ohio State University, suggests often co-occurring health conditions (such as disruptions in mental health, traumatic brain injury and the impact of strangulation, as well as substance use) often caused by abuse and resulting in disability are prevalent among almost all domestic violence survivors accessing DV program services (including shelter, community-based advocacy, and criminal justice advocacy) as well as other crime victim services. Our findings suggest the vast majority of survivors who access advocacy services have had experiences that clearly impact the brain and cause the following symptoms:

Physical	Emotions	Thinking
<ul style="list-style-type: none">• Headaches• Sleeping problems• Sensitive to light or noise• Dizziness• Balance problems• Fatigue• Seizures	<ul style="list-style-type: none">• Worries and fears• Panic attacks• Flashbacks• Sadness• Depression• Hopelessness• Anger or rage	<ul style="list-style-type: none">• Remembering things• Understanding things• Paying attention or focusing• Following directions• Getting things started• Figuring out what to do next• Organizing things• Controlling your emotions or reactions

Most service providers assume that people accessing services can remember appointments, understand conversations, concentrate and focus, set goals and follow case plans, stay motivated, and figure out next steps. Psychological and physical trauma can hinder the brain's ability to do almost all of these complicated brain functions. The information we are learning through this research challenges programs to find ways to adjust services and accommodate the physical, emotional and cognitive functional limitations caused by trauma, mental illness, brain injury, and substance use.

Lesson Learned: *Issues are Connected*

Lesson 3: The field knows domestic violence impacts mental health. But programs struggle with effectively providing services and meeting the needs of survivors with mental illness, especially with the lack of availability of trauma-informed mental health services.

Almost all survivors accessing services experienced mental health coercion. Examples of mental health coercion include ways in which abusers deliberately cause a survivor to feel crazy or like they are losing their mind, use mental health struggles against them, or discourage or prevent survivors for getting help for their mental health. In individual interviews with survivors, over 90% of survivors reported some sort of mental health coercion. Staff were well aware of the ways in which mental health coercion, domestic violence, and trauma can impact a survivor's emotional well-being. Staff also expressed hesitancy to label a survivor with a mental health diagnosis, especially in the context of the trauma associated with domestic violence, and the possible ways in which a diagnosis could be used against them by their abusive partner or by a system or organization that they are seeking help from.

...over 90% of survivors reported some sort of mental health coercion.

While most domestic violence advocates have some knowledge or training on mental illness and understand the connection between DV and mental health, translating that knowledge into effectively accommodating needs in services has been elusive and difficult.

Program staff shared that they found it difficult to meet the needs of those with severe mental illness, especially in a shelter setting. Staff recognized some survivors would benefit from additional clinical support or mental health services, but expressed frustration by the inability of domestic violence survivors to access trauma-informed mental health services. Staff reported challenges with long wait lists, mental health providers discontinuing services after survivors missed appointments, and a lack of understanding of the role domestic violence, coercive control, and trauma might have in their presenting symptoms. Staff also recognized the larger structural problem of the lack of comprehensive mental health services available in our country, which domestic violence victims would benefit from.

For more information on findings related to mental health see our article in the peer reviewed Journal of Family Violence listed below.

Mengo C, Beaujolais B, Ramirez R, Kulow E, Brown A, Nemeth JM. Knowledge and Perspectives of Domestic Violence Service Providers about Survivors with Mental Health Disability. Journal of Family Violence. 2019

Lesson 4: The field doesn't know that domestic violence victims might have brain injuries. While domestic violence victims report incredibly high levels of head trauma, brain injury is largely unidentified, rarely addressed, and not well understood by domestic violence programs.

Staff had little knowledge or training on brain injury. Staff were hesitant to address brain injury directly, as they felt like they didn't know enough about the topic, lacked the tools to properly intervene, and did not want to do additional harm. In contrast to mental health findings that expressed knowledge of available services but frustration with the inability to access services, staff had little awareness of what types of services might be helpful for someone with a possible brain injury, and no relations with brain injury services.

In ODVN's initial needs assessment, Domestic violence program staff reported they felt unequipped to address partner inflicted brain injury (defined as disruptions to brain caused by blows to the head or strangulation by a partner). None of the domestic violence agencies had any of the following in place and needed:

- Policies or procedures on identifying, acknowledging and responding to head injuries.
- Advocate tools or guidance to assist with providing accommodations in services.
- Educational materials designed for domestic violence victims on these topics.
- Screening questions and guidance on how to ask and respond.
- Training on traumatic brain injury and strangulation that becomes a routine part of any agency's initial or continuing education.
- More knowledge and tools to feel more confident and comfortable addressing these topics.

Survivors accessing services also shared that they weren't regularly asked about traumatic brain injury and strangulation, didn't get education and information about the impact of head injury, weren't aware of symptoms or problems that could be connected to their head injuries, and weren't provided accommodations or referrals to possible follow up care.

The implementation of the CARE framework with agency programs and the development of tools for advocates to address brain injury has fundamentally altered this reality. In an evaluation after the implementation of CARE, staff reported a marked increase in knowledge of the interrelations between DV, mental health and brain injury, and a significant increase in comfort and confidence in addressing hits to the head, strangulation, mental health and suicide with survivors.

Domestic violence programs must become proficient in identifying, acknowledging and responding to brain injury. Partner inflicted brain injury must become a standard training for professionals and volunteers working with survivors of domestic violence.

For more information on findings related to partner inflicted brain injury, see the article listed below, a peer reviewed article published in the Journal of Family Violence.

Nemeth JM, Mengo C, Ramirez R, Kulow E, Brown A. Provider perceptions and domestic violence (DV) survivor experiences of traumatic and anoxic-hypoxic brain injury: implications for DV advocacy service provision. *Journal of Aggression, Maltreatment & Trauma*. 2019.

Lesson 5: Brain injury in the context of domestic violence (termed partner inflicted brain injury) is **markedly different** from other commonly studied brain injuries, including brain injuries caused by accidents, sports, and combat.

Partner inflicted brain injuries are intentional assaults by a loved one. Existing research in the brain injury field has centered on injuries related to automobile accidents, sports, and traumatic brain injuries in military combat situations. A brain injury caused by domestic violence is very different and changes the way professionals identify, intervene, and promote recovery and healing. The brain injury field has depended on strategies for identification that include educating others (including coaches, parents, teachers, bystanders, etc.) to recognize possible concussions. The recovery recommendations, such as return to play and return to learn protocols, often mandate rest or reduced activity, avoidance of stress, and a gradual return to activities as tolerated.




Due to the context in which they occur, current approaches to identify, treat, and heal from concussions or other more severe brain injuries related to sports and in other situations aren't effective or feasible when a brain injury is caused by domestic violence. Survivors, themselves, often don't recognize that hits to the head and/or strangulation can cause brain injury. There are no coaches or witnesses to train on identifying and intervening. Survivors face very real barriers and safety risks to accessing medical care or evaluation after an event. A victim is attempting to heal from the almost universally unidentified brain injury in a traumatic and unsafe environment.

ODVN has taken a national lead on developing and advocating for a new conceptualization of brain injury in this context that addresses the complexities, named partner inflicted brain injury. By correctly understanding and defining the problem it will lead to the development of approaches that can help shape effective interventions and responses.

“ODVN has taken a national lead on developing and advocating for a new conceptualization of brain injury...”

ABOUT LOCAL AND STATEWIDE IMPLEMENTATION OF BEST PRACTICES

Domestic violence programs work in a trauma-based, crisis oriented field with high turnover. Implementing strategies on a local and statewide level to change attitudes and increase access to services is a challenging proposition. Transforming programs and agencies to change practices requires unique strategies that increase local program buy in and takes the context of service provision into account.

-  Findings on effectively addressing brain injury and mental health in domestic violence services:
-  The CARE framework is a critically important tool for acknowledging, identifying, and responding to these often unrecognized invisible disabilities.
-  When programs are provided with tools and training developed by CARE and supported in using them, it can transform their services and make advocacy more accessible to all survivors.

Organizations can adapt CARE as a successful framework for implementing statewide and/or multi-agency collaboration projects.

Lesson 1: The CARE framework is a critically important tool to effectively identify, acknowledge, and respond to these often unrecognized invisible disabilities.

Increasing access to program services for those with unidentified, invisible disabilities (like brain injury and mental health) as opposed to recognized, visible disabilities (such as a physical disability) requires a different approach. Mental health and brain injury disabilities are unique in a number of ways. Survivors are often unaware of a possible brain injury, and don't know some of their emotional or cognitive struggles could be connected to it. Survivors who struggle with their mental health have often had this used against them, by abusers and others, and there is still enormous stigma surrounding mental health and the impact of brain injury, with many survivors trying to hide or mask symptoms or struggles.

Many programs have made significant improvements in making their programs physically accessible. We are now challenged to identify physical, cognitive and emotional challenges related to mental health or a brain injury. Then we must develop strategies to make programs emotionally and cognitively accessible. The CARE framework and the tools developed as a part of this project, as well as the accommodations provided, can effectively increase access to effective services.

The CARE framework helps local programs identify possible accommodations to account for the physical, emotional, and cognitive impact of mental health, brain injury and other issues. Examples of accommodations developed as a part of this project include:

- Provide earplugs, headphones, sunglasses, or adjust lighting if necessary
- Help identify conditions that facilitate sleep (music, darkness, quiet, etc.)
- Slow down information, plan for additional time
- Repeat things frequently and have them repeat back to you, in their own words, what you talked about
- Provide written information and document conversations as much as possible, for recall
- Provide calendars, notebooks and checklists to help with memory
- Check in with survivor often, particularly in the beginning of their stay
- Have staff wear nametags for memory or processing challenges

It's easy to become frustrated with a client or to not understand why the behavior that we are seeing and this gives us, 'oh, well this makes perfect sense.' [With CARE] here are some ways we can help them with that.

Administrator staff at a local domestic violence agency

Lesson 2: When programs are provided with tools and training developed by CARE and supported in using them, it can transform their services and make advocacy more accessible to all survivors.

Domestic violence program staff provide excellent, important services. Survivors reported great satisfaction with domestic violence services offered and advocates at program staff are enthusiastic and eager to provide the best services possible. They were very interested in training and strategies to help them better meet the needs of survivors.

DV program staff also work in very challenging trauma-based environments. Domestic violence survivors often come to services in an incredibly vulnerable time of their lives with extensive needs. The project success hinged on a couple of strategies—in response to the needs assessment, ODVN developed simple advocacy tools and basic accessible training that made addressing brain injury and mental health feasible for advocates. ODVN empowered agencies and advocates to figure out what CARE looked like in their setting and provided support that was helpful to them. Agencies that had a staff member who really believed in CARE and the importance of discussing and accommodating needs related to brain injury and mental health reported more shifts in attitudes and increased access. The staff members didn't need to be an administrator or agency leader—they just needed to have influence with other staff members and access to tools and training. That leads to the second component, which was designing an approach that made sense for agencies with high turnover and limited funds and time for training. Staff must have direct access to tools and training, and the training needs to focus on building connections to effectively using the tools with DV survivors. This drove the development of online training that was simple and to the point.

“The advocacy tools are incredibly helpful and extremely informative for both clients and myself.

Staff, Post-CARE online survey

“A lot of this resource material, we can hand it to them and it gives them a validation. What I feel and what this has done to me is valid.

DV Staff, CARE process evaluation focus group

Lesson 3: Organizations can adapt CARE as a successful framework for implementing statewide and/or multi-agency collaboration projects.

Without intentionally doing so, ODVN adapted CARE from an individual level intervention framework to a statewide level strategy for this initiative. ODVN’s approach to engagement with local domestic violence programs and an increasing cross-system collaboration followed a system advocacy care process:

CARE for Program Development:



CONNECTING and building relationships with project partners by bringing partners together to explain the goals of the project, people’s roles, and learn about what partners needed from the collaboration, and visiting the projects several times to learn about their programs.



ACKNOWLEDGE the complexities, challenges and opportunities when tasked with addressing brain injury and mental health in domestic violence programs. Domestic violence programs are already extremely underfunded, crisis oriented, and we needed to learn from them how to develop a project that would be realistic and feasible in these environments.



RESPOND by integrating all feedback into thoughtful and intentional design of training, materials, technical assistance, and resources developed for programs to use.



EVALUATE by adjusting and changing next steps or phases of the project, and improving future programming based on lessons learned, as well as changing strategies for training and support to meet the needs of programs.

CONCLUSION

Domestic violence services save lives and do it in a way that empowers, respects, and supports survivors. Domestic violence advocates care deeply about their work and want to provide the best services possible.

What ODVN learned from this project—about traumatic brain injury, strangulation, mental health, and its intersection with other common struggles domestic violence survivors experience—has transformed the work of the organization. ODVN has developed new, groundbreaking projects on meaningful access to services and deepening our understanding of partner inflicted brain injury. Our findings highlight the important opportunity domestic violence programs have to adjust their current services, processes, and design to be accessible and effective for survivors of abuse, so survivors can move forward on their journey towards safety and healing.



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