Intimate Partner Violence and Women with Severe Mental Illnesses: Needs and Challenges from the Perspectives of Behavioral Health and Domestic Violence Service Providers

Tonya B. Van Deinse, PhD, MSW
Amy Blank Wilson, PhD, MSW
Rebecca J. Macy, PhD, MSW
Gary S. Cuddeback, PhD, MSW, MPH

Abstract

Women with severe mental illnesses face high rates of violence victimization, yet little is understood about the unique needs and challenges these women present to the domestic violence and behavioral health agencies that serve them. To help address this knowledge gap, focus groups were conducted with 28 staff members from local behavioral health and domestic violence service agencies. Results from this exploratory study suggest that women with severe mental illnesses who experience intimate partner violence face additional challenges that exacerbate behavioral health and domestic violence issues and put these women at greater risk for continued victimization. DV and behavioral health agency staff experience individual-, provider-, and system-level barriers to serving this high-risk, high-need population. Recommendations and implications for domestic violence and behavioral health providers are discussed.

The incidence of violence victimization among women with severe mental illnesses is a pressing concern for both behavioral health and domestic violence providers. Women with severe mental illnesses face significantly higher rates of violence victimization (e.g., physical or sexual abuse or assault) compared to men with severe mental illnesses[1–6] and men and women without mental

Address correspondence to Tonya B. Van Deinse, PhD, MSW, School of Social Work, University of North Carolina, 325 Pittsboro Street, CB#3550, Chapel Hill, NC 27599, USA. Email: tbv@email.unc.edu.
Amy Blank Wilson, PhD, MSW, School of Social Work, University of North Carolina, Chapel Hill, NC, USA.
Rebecca J. Macy, PhD, MSW, School of Social Work, University of North Carolina, Chapel Hill, NC, USA.
Gary S. Cuddeback, PhD, MSW, MPH, School of Social Work, University of North Carolina, Chapel Hill, NC, USA.
This project was supported by a grant from the Armfield Reeves Innovation Fund.

illness.[2,3,5–8] Best estimates suggest the rate of intimate partner violence (IPV) or domestic violence (DV) among women with severe mental illnesses varies between 22 and 76% depending on the definition of severe mental illness, the timeframe examined (e.g., past year prevalence versus lifetime prevalence), the type of victimization (e.g., physical assault versus sexual assault), and mental health diagnosis.[1,3,4,7 9] Moreover, there is evidence that violence victimization can exacerbate symptom severity for women with severe mental illnesses.[10]

Despite the increased risk of IPV and DV among women with severe mental illnesses and the growing evidence supporting the effectiveness for DV interventions among women in general,[11] the development and implementation of behavioral health interventions adapted or created for women with severe mental illnesses who experience IPV and/or DV is limited. In addition, there are no recommended or standard protocols in DV or behavioral health service agencies for screening and addressing the complex behavioral health and safety needs of women with severe mental illnesses who experience IPV.[12] In this context, understanding the challenges and barriers to serving women with severe mental illnesses who experience IPV from the perspective of both behavioral health and DV service providers is an essential first step in developing screening and assessment protocols and evidence-based interventions for this high-risk, high-need population. With the exception of one study,[13] there is little in the literature examining the experiences of behavioral health and DV service providers who serve women with severe mental illnesses who experience IPV. To address this research gap, focus groups were conducted with staff members of behavioral health and DV service providers to explore the challenges they experience when serving women with severe mental illnesses who experience IPV.

Method

This exploratory qualitative study investigates the experiences of community behavioral health and DV agency staff members who serve women with severe mental illnesses who have experienced IPV. Focus groups were conducted using a semi-structured interview guide designed to gain a better understanding of behavioral health and DV agency staff members' perceptions of the challenges and barriers encountered when working with women with severe mental illnesses who experience IPV. This study was reviewed and approved by the institutional review board at (omitted to preserve anonymity).

Recruitment and sample

One focus group was conducted at four different agencies, which included two local behavioral health agencies and two local DV agencies. These agencies were selected for their expertise serving women with severe mental illnesses and women who experience IPV. The co-principal investigators of this project had ongoing research relationships with these agencies and approached each agency director to invite their agency's participation in the study. All agency directors who were approached agreed to allow their staff to participate. In total, 28 staff members from the four agencies participated—14 staff members were from one of two behavioral health agencies and 14 staff members were from one of two DV agencies. Focus groups ranged from 3 to 11 participants.

Among the 28 focus group participants, 75% ($n = 21$) were female, 14% ($n = 4$) were male, and 11% ($n = 3$) did not indicate their gender. Also, 64% ($n = 18$) identified as White/Caucasian, 7% ($n = 2$) identified as Black/African American, 4% ($n = 1$) identified as American Indian, 11% ($n = 3$) identified as other, and 14% ($n = 4$) did not indicate their race. In terms of ethnicity, 4% ($n = 1$) identified as Hispanic or Latino. The average age of respondents was 40.08 ($SD = 13.67$), 64% ($n = 18$) had a graduate degree, and 18% ($n = 5$) had completed college or technical school.

With respect to work experience, 57% ($n = 16$) of the participants reported that they spent more than half of their time working directly with clients and 57% ($n = 16$) of the respondents had

current or previous experience working in DV services. Also, 79% ($n = 22$) reported that they had current or previous experience working in agencies that provided behavioral health treatment.

Data collection

The research team conducted a total of four focus groups at four different agencies—two behavioral health and two DV agencies—which enabled the research team to understand the unique and shared experience of providers from both types of agency. Two members of the research team conducted all four focus groups, which were held on-site at each agency and lasted between 60 and 90 min. All focus group discussions were audio-recorded and transcribed verbatim by a professional transcriptionist. In order to ensure that focus group participants had a shared understanding of key terms that would be used, researchers provided participants with the following definitions:

- *Intimate partner violence* (IPV), *domestic violence* (DV), and *dating violence*: a romantic or intimate relationship (dating, living with, or married to) with a person who is controlling, threatening, or violent. IPV, DV, and dating violence can be psychological (e.g., insults, swearing, shouting, yelling, name calling), physical (e.g., hitting, kicking, slapping, shoving, strangulation/choking, attacking with or without a weapon), or sexual (forced to have sex with words, threats, or violence)
- *Sexual assault*: any unwanted sexual activity, ranging from unwelcomed groping and fondling to forced sexual intercourse
- *Severe mental illness*: a chronic and disabling psychiatric condition—such as schizophrenia, bipolar disorder, or major depressive disorder—defined by the conjunction of diagnosis, duration, and disability[14]

Focus group participants were given the opportunity to ask questions and discuss these definitions before beginning each group. During the focus groups, participants were asked questions from a semi-structured interview guide pertaining to their experiences working with women with severe mental illnesses and IPV, such as (a) the challenges that IPV and severe mental illnesses present to mental health and DV service providers; (b) the extent to which women with mental illnesses sought services for IPV, used legal services or any other services to address IPV; (c) the extent to which mental health and DV services staff were cross-trained in mental illness and IPV; (d) whether agency staff were aware of promising practices for women with mental illnesses and IPV; and (e) whether staff had specific recommendations about serving women with severe mental illnesses and IPV.

Data analysis

Data analysis occurred in two phases. During the first phase, a team of coders used a general inductive approach[15] to code the raw data from the focus groups, resulting in a number of descriptive categories. In the second phase, the coders reviewed the initial categories and identified three broad categories, each of which contained several specific topics or subcategories. To enhance the rigor of the coding process, two coders conducted an independent parallel coding process.[15] Overlap between the two independently coded schemes was examined by a third researcher who then merged the two coding schemes into a final coding structure. The final coding structure was then verified by all members of the coding team.

Results

The data analysis yielded three broad categories of qualitative data: (a) service challenges related to client characteristics (i.e., client-level challenges), (b) service challenges workers experience

when providing behavioral health and domestic violence services directly to people with severe mental illnesses and IPV (i.e., worker-level or staff-level challenges), and (c) service challenges that are related to organizational and administrative issues associated with service delivery in the behavioral health and DV service systems (i.e., system-level challenges). The findings presented below are organized within each of these three categories.

Client-level challenges

Behavioral health and DV agency focus group participants identified three client-level challenges to serving women with severe mental illnesses and IPV: (a) clients with severe mental illnesses and IPV present with high rates of other co-occurring or comorbid issues, such as co-occurring substance use or physical health problems; (b) clients with severe mental illnesses and IPV present with heightened reluctance to engage in behavioral health treatment; and (c) clients with severe mental illnesses and IPV lack stable and reliable prosocial support systems. Descriptions of each of these areas are provided below.

High rates of co-occurring issues

Focus group participants noted a number of problems that compound the challenges of addressing the behavioral health and safety needs and/or conducting accurate assessments and treatment planning for women with severe mental illnesses and IPV. For instance, the treatment needs of women with severe mental illnesses and IPV are often confounded by clients' multiple mental health diagnoses, as explained by one DV service provider: "In addition to the bipolar and sometimes schizophrenia, there's PTSD and depression and they've had multiple [diagnoses], and they don't even know half the time what their diagnoses are…" Focus group participants also noted that women with IPV and severe mental illnesses often experienced other co-occurring problems and co-morbidities, such as substance use issues, periodic homelessness, and forced prostitution that exacerbated mental health symptoms and placed women at an even greater risk of continued IPV and other forms of victimization.

DV and behavioral health agency staff also noted that women who are pregnant and women who are undocumented present especially complex challenges to treatment and safety planning. One DV service provider explained that pregnant women with severe mental illnesses—particularly schizophrenia and bipolar disorder—have to "cope with the hormonal changes and not being able to take any medication and still try to control their responses." In addition, clients who are undocumented and who have limited English proficiency have additional barriers to leaving their abuser and seeking treatment—namely, challenges associated with getting a job and reporting abuse. In particular, one agency staff member paraphrased her client's concerns noting "I have no immigration status if I separate from my husband who beats the crap out of me… I can't get a job…I don't speak English."

Reluctance to engage in mental health treatment

Another common theme was that DV and behavioral health providers expressed that many women with IPV and severe mental illnesses are reluctant to engage in behavioral health treatment and that this reluctance seemed to stem from previous negative experiences these women had with behavioral health service providers. For instance, one participant noted that some women have "been through the rotating door of therapists" because of changes in the behavioral health service system and are "burned out." Another respondent further explained the revolving door problem by stating, "It's hard to survive that transition from therapist to therapist and [even though] they know they need it, after a certain point they get out [of treatment]."

DV and behavioral health staff also noted that clients with IPV and severe mental illnesses can become reluctant to engage in behavioral health services when therapists "push too hard" for a client to leave her abuser before she is ready to take this step. A description of this problem is articulated well in the following quote:

> And my experience for most of the folks who've been to those services, they come back and say, "I have not gotten the help that I needed because they're just not listening to me. That's what I really want; I want someone to listen to what's going on and not tell me what to do. Give me some space to figure it out. So, I'm staying in the shelter, you know. It doesn't mean I'm ready to divorce my husband or whoever it is or I'm gonna do that on my own. It just means I need a break because I've been running the streets for 48 hours smoking crack. I've been getting the crap kicked out of me and I can't go home cause it's just gonna get worse."

Lack of stable and reliable support systems

DV and behavioral health staff also reported that support systems can play a major role in engaging and sustaining behavioral health treatment for women with severe mental illnesses who experience IPV. However, participants noted that women with severe mental illnesses and IPV have often exhausted their support systems. One focus group participant described how a woman's support system can deteriorate after years of abuse and that this deterioration is compounded by chronic mental illness:

> We have the folks that are more chronic, and they've had their illness for years and years, which means their supports have just dwindled away to, at best, being a family member or two, you know. But it's commonly not much at all. And so, you know, in violent situations people tend to be isolated. But for our folks, there's sort of that double layer of isolation because with their illness, there's no one around in terms of support, so it's really a double whammy.

Moreover, several DV and behavioral health staff noted that women with IPV and severe mental illnesses who have support systems in place tend to fare better and make more significant progress compared with those who do not have these support systems. In the following quote, one DV agency staff member described the positive impact that support systems can have for women with severe mental illnesses and IPV:

> Women who do come into the [DV] shelter who already have support systems in place tend to fare a lot better. They can get transportation; just simple things like that or they can have somebody lend them $3.00 so they can go get their medication. Simple stuff like that—where if they don't have that [support], boy, do they really struggle.

Worker-level or staff-level challenges

DV and behavioral health agency staff reported experiencing two types of challenges when working with women with severe mental illnesses and IPV—developing therapeutic rapport and conducting accurate assessments.

Developing therapeutic rapport

Both behavioral health and DV service providers reported experiencing challenges when trying to build trust and therapeutic rapport in their working relationships with clients who experience both severe mental illnesses and IPV. Respondents indicated that they believed women who experienced IPV had greater difficulty trusting others and often took longer to engage in the worker-client relationship. One mental health service provider said that "trust…was about having to sort of feel out that I wasn't going to force them into doing things they weren't comfortable with," such as taking steps to leave their abuser when they were not ready.

DV and behavioral health agency staff also reported that the therapist's gender can compound the difficulty of building a trusting worker-client relationship. Male study respondents who were

behavioral health service providers indicated that some women might have difficulty trusting male staff and might not feel comfortable discussing their abuse with a male provider. For example, one male participant described the difficulty of building a therapeutic relationship with the women he served noting that women clients with severe mental illnesses were "hesitant to…get into all the details of a comprehensive assessment" and that his presence seemed to evoke "a lot of distrust."

DV and behavioral health agency staff reported that lack of trust also affects whether a woman discloses abuse. The staff from the local behavioral health centers noted that without trust and rapport, their women clients were less likely to talk about current or past physical, sexual, or emotional abuse. In turn, a staff member's lack of knowledge about a client's current or past abuse made it difficult for the provider staff member to respond effectively and make appropriate referrals to resources. Further, a lack of trust can affect help-seeking behaviors, as evidenced by one agency staff member's statement that some women who knew of other available resources did not access those resources because the women had not built a trusting relationship.

Conducting assessments

Both behavioral health and DV service providers indicated that they experienced challenges determining which of a client's symptoms were related to a mental illness and which might be associated with IPV. One DV provider described how the combination of past abuse and the symptoms of psychosis made it seem like the abuse was current:

> I can think of a small number of cases where, even if the abuse is not currently going on, [symptoms of psychosis] make them feel as if it's still going on. I have no way of knowing whether it's true or not but they really feel like they're being victimized or stalked from a previous abuser from afar. And, you know, "he's gonna find me" and that sort of thing. And it feels very paranoid and delusional. So, they're in this constant state of feeling victimized. And it could be true.

DV agency staff also noted that it was difficult to determine which behaviors were attributable to symptoms of mental illness and which were "a result of [the abuse] they've been through" or a "normal reaction to the trauma they're experiencing." These DV staff noted that situations where a woman's mental illness was not accurately identified put the staff member at risk of using an inappropriate or harmful intervention, which may trigger unintended responses.

System-level challenges

DV and behavioral health agency staff identified a number of system-level service challenges: (a) a lack of integrated behavioral health and DV treatment options, (b) lack of cross-training opportunities, (c) low levels of service coordination between DV and behavioral health services, (d) instability of behavioral health services, and (e) medication compliance policies at DV and homeless shelters.

Integrated treatment options

Behavioral health agency staff indicated that the services available to individuals with severe mental illnesses with IPV in the behavioral health system were not necessarily the services that these individuals needed. In particular, participants noted that few counseling options existed for women with severe mental illnesses that integrate treatment for severe mental illness and DV:

> I think folks with psychosis are being shunted into straight [medication] management or then case management or that type of support, maybe [assertive community treatment] services. But I think the kind of work that's done here [therapeutic counseling] tends to touch on some of those deeper places.

Because of a lack of counseling and services for IPV in the behavioral health service system, women with severe mental illnesses often turn to DV service providers for their counseling needs.

Although this approach might be beneficial from the client's perspective, DV service providers noted they have limited training and technical expertise in mental health counseling, and DV staff typically do not have the capacity to provide the treatment needed to address all of the behavioral health needs of women with severe mental illnesses and IPV.

Cross-training opportunities

Similarly, both behavioral health and DV agency staff indicated that the lack of formal training in DV among behavioral health professionals was potentially detrimental to women with mental illness and IPV for a variety of reasons. First, behavioral health professionals who lack formal training in IPV might not properly identify the signs and risk factors associated with IPV. Second, behavioral health professionals without specialized IPV training might not be equipped to address the complex issues presented by IPV. To this point, respondents representing DV agencies indicated that this expertise does not "exist within the regular mental health community" and the "basic counselor doesn't know enough and it almost does more harm than good if you don't understand the basic dynamics of what you're dealing with."

Similar to mental health clinicians, DV staff noted that lack of cross-training in identifying and treating mental illnesses was a barrier to serving women with severe mental illnesses who experience IPV. These respondents reported that DV service providers' knowledge of and skills in working with women who have severe mental illnesses most often come from experience rather than formal training. Many of the respondents were forthcoming that they lacked the expertise needed to address behavioral health issues among the women they served.

Service coordination

Behavioral health staff noted the lack of protocols for identifying and addressing DV among the women served in their agencies. In the absence of formal training or agency procedures, mental health clinicians relied on their clinical expertise to address DV and to make referrals to DV agencies. However, several behavioral health staff members noted that even after referrals are made, there was little collaboration or communication across agencies, which was due, at least in part, to confidentiality policies and a lack of recommended best practices for service coordination between the DV and behavioral health sectors. DV staff noted that due to their lack of training and education about mental illness, they were often unable to make informed and targeted referrals to behavioral health providers on behalf of women who exhibited clear symptoms of mental illness, despite the fact that, for all women they encountered, they routinely recommended connecting with a behavioral health provider.

Instability of behavioral health services

Both DV and behavioral health agency staff noted that instability and inconsistency in the behavioral health service system has left DV and mental health providers feeling that "even if [clients] are connected, it's very tenuous, like [services] could just go away at any point." Agency staff noted that when services run out, or when there is high turnover in the staff of a behavioral health agency, clients lose their therapists and any rapport that had been built. DV and behavioral health staff suggested that for women with mental illnesses and IPV, having their behavioral health services "in flux" might bring up "those underlying issues of abandonment and abuse" at critical moments when they have finally had "the courage to tell these horrible things to [someone]."

Medication policies

DV agency staff noted the policies and regulations regarding crisis and shelter services presented a significant barrier to serving women with severe mental illnesses who experience IPV. In

particular, focus group respondents reported that many DV programs have policies requiring individuals with a diagnosed mental health condition to have at least 30 days of medication compliance before they are allowed to stay in a shelter. Thus, many women with severe mental illnesses are denied access to shelter services. Some examples provided included women who were recently prescribed medications, women whose abusive partners confiscated their medications, or women who stopped taking their medications for whatever reason but who were still in need of crisis services and safe housing. Although DV and behavioral health staff acknowledged a need for policies to ensure women with severe mental illnesses were receiving appropriate treatment for mental illnesses, the DV service providers also acknowledged that such policies could force many women to remain in violent relationships for lack of anywhere else to go.

Implications for Behavioral Health

Women with severe mental illnesses are at greater risk of experiencing IPV but DV and behavioral health agencies that work with this high-risk, high-need population are often ill-equipped to handle their complex needs. Results from this exploratory study illuminate a number of challenges experienced by DV and behavioral health agency staff who are on the front lines providing services to women with severe mental illnesses who experience IPV. For example, DV and behavioral health agency staff recognized that co-occurring problems—such as substance use, homelessness, and lack of social support—increase the difficulty of addressing current behavioral health and IPV issues among women with severe mental illnesses who experience IPV, and put these women at risk for continued victimization.[2,8,9] To exacerbate matters, the risks and challenges of chronic victimization are intensified by the lack of support networks—both formal and informal—among women with severe mental illnesses who experience IPV and have an especially difficult time establishing trust and rapport with staff from DV and behavioral health agencies. Moreover, the full range of support and services needed by women with severe mental illnesses who have experienced IPV is lacking in both the behavioral health and DV service systems.

Practice recommendations

Best practices for assessing and screening DV in a health care setting emphasize building a trusting relationship with survivors.[16,17] However, existing research shows women with severe mental illnesses and IPV face a number of co-occurring problems—e.g., substance misuse to manage psychological effects of mental illness and trauma symptoms of victimization,[18] exacerbation of mental health problems,[10] increased risk of homelessness,[8,10] frequent re-victimization,[9] and untreated trauma[19,20]—which often impede agency staff members' efforts to establish a trusting client-worker relationship. Such dynamic challenges were echoed and underscored by DV and behavioral health agency staff who participated in this study.

Trust and rapport-building could be addressed in a number of ways. For example, behavioral health and DV agencies could implement advanced, skill-based cross-training for DV and behavioral health agency staff that is guided by trauma-informed principles. Such advanced training could focus on building staff members' understanding of how trauma, IPV, mental health, substance use, and other comorbid problems are interrelated[17,19] and enhancing staff members' capacity to build a therapeutic relationship that is consistent, safe, non-shaming, and collaborative.[17,19] Although cross-training is not a novel recommendation, the respondents' acknowledgement that service providers were ill-equipped to serve women experiencing both mental illness and IPV indicates that prior recommendations for such training have not been acted on and the need for staff with cross-training in behavioral health and DV services continues.

It is also possible that including survivors of DV in the agency's service delivery[19]—such as a peer support worker model—could improve the trust and rapport between the client and staff

member. The use of peer support models is growing in the behavioral health system and is commonly used to deliver DV services.[12,19,21] Thus, developing peer-support programs designed specifically for women with severe mental illnesses and IPV could prove beneficial.

Policy recommendations

DV and behavioral health providers should create protocols for universal, standardized assessments[17,19] that include both IPV and mental health screenings, and DV shelters and agencies should have clinical staff with relevant mental health training available on-site to conduct mental health screenings and handle emergent IPV and /or mental health crises. Policies developing universal screening practices should follow a trauma-informed approach that clearly defines how information about mental health and IPV will be used, avoids asking the client unnecessary questions, limits the emotional burden of the screening tool, and communicates to the client that answering screening questions is voluntary.[17] Further, agencies and professionals working with women survivors of IPV who have severe mental illnesses (e.g., mental health providers, DV agencies, law enforcement, first responders) could consider establishing memoranda of agreement to guide interagency collaboration regarding information sharing, referrals, and timely service access. Such memoranda could also include case consultations in which agencies and clients work collaboratively to address clients' complex needs and barriers to accessing services and supports.

Finally, behavioral health and DV agency staff who participated in the study emphasized how restrictive policies at homeless shelters and DV shelters (e.g., medication compliance requirements) often leave women with severe mental illnesses without options for crisis housing. In the absence of funding to build crisis housing specifically for those with co-occurring IPV and mental illness, DV and homeless shelters should explore options for such accommodations and should consider partnering with local behavioral health and law enforcement agencies to provide additional support in the event of a crisis, as well as to provide first responders trained to assist with this population, particularly those crises in which housing is a problem.

Implications for research

Beyond developing protocols for screening and referring for services, behavioral health and DV service providers need effective interventions that simultaneously address mental health, safety, and recovery for women with severe mental illnesses who experience IPV. Researchers should partner with local behavioral health and DV agencies to modify existing interventions to include trauma-informed approaches that meet the complex needs of clients with severe mental illnesses who experience IPV. Researchers should then test the feasibility and effectiveness of these interventions to be delivered in behavioral health and/or DV provider agencies. In addition to intervention research, investigators should focus on the firsthand experiences of IPV survivors with severe mental illnesses regarding their access to behavioral health and DV services. Such research will provide the necessary insights into the barriers and facilitators of accessing services and guide researchers and practitioners in improving service delivery and intervention development.

Study strengths and limitations

The research presented here is a small exploratory study that builds our understanding of the challenges that behavioral health and domestic violence service providers experience when working with women with severe mental illnesses who experience IPV. However, this study focuses on the perspectives of staff members at behavioral health and DV agencies and lacks the perspectives of clients. Given that clients will have a different perspective of service delivery, a comprehensive understanding of the barriers and challenges of treatment needs would include the

patients' perspectives. Thus, future research incorporating clients' perspectives might identify service barriers and challenges of which providers were unaware. Although our study design incorporated multiple strategies to enhance the authenticity of the findings (e.g., recording focus groups and transcribing results verbatim, using inductive coding strategies, and multiple coders to analyze the data), the possibility remains that the results presented do not fully represent the data as members intended. A final limitation stems from the small sample size of local service providers who were included in this study, which limits the generalizability of the findings presented here. Nevertheless, results from this study provide initial recommendations to address the interface of severe mental illness and DV. It is our hope that these findings will inspire others to work on practices, system changes, and policies to address the needs of this population.

Conclusion

Women with severe mental illnesses experience high rates of IPV and present significant challenges to behavioral health and domestic violence agency staff. Behavioral health and DV agencies need enhanced training, specialized interventions, universal screening procedures, enhanced attention to basic needs (e.g., housing), and greater peer and informal support networks for women with severe mental illnesses experiencing IPV.

Compliance with Ethical Standards

Conflicts of Interest The authors declare that they have no conflict of interest.

References

1. Howard LM, Trevillion K, Khalifeh H, et al. Domestic violence and severe psychiatric disorders: Prevalence and interventions. *Psychological Medicine*. 2010;40:881–893.
2. Latalova K, Kamaradova D, & Prasko J. Violent victimization of adult patients with severe mental illness: A systematic review. *Neuropsychiatric Disease and Treatment*. 2014;10: 1925–1939.
3. Mauritz MW, Goossens PJJ, Draijer N, et al. Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*. 2013; 4:1–15.
4. Oram S, Trevillion K, Feder G, et al. Prevalence of experiences of domestic violence among psychiatric patients: Systematic review. *British Journal of Psychiatry*. 2013;202:94–99.
5. Trevillion K, Oram S, Feder G, et al. Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. *PLoS One*. 2012;7(12):e51740.
6. Choe JY, Teplin LA, Abram KM. Perpetration of violence, violent victimization, and severe mental illness: Balancing public health concerns. *Psychiatric Services*. 2008;59:153–164.
7. Hughes K, Bellis MA, Jones L, et al. Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. *Lancet*. 2012;379(9826):1621–1629.
8. Khalifeh H, Dean K. Gender and violence against people with severe mental illness. *International Review of Psychiatry*. 2010;22:535–546.
9. Friedman SH, Loue S. Incidence and prevalence of intimate partner violence by and against women with severe mental illness. *Journal of Women's Health*. 2007;16:471–480.
10. Goodman LA, Rosenberg SD, Mueser KT, et al. Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin*. 1997;23:685–696.
11. Stover CS, Meadows AL, Kaufman J. Interventions for intimate partner violence: Review and implications for evidence-based practice. *Professional Psychology: Research and Practice*. 2009; 40:223–233.
12. Macy RJ, Giattina MC, Parish SL, et al. Domestic violence and sexual assault services: Historical concerns and contemporary challenges. *Journal of Interpersonal Violence*. 2010; 25(1):3–32.
13. Nyame S, Howard LM, Feder G, et al. A survey of mental health professionals' knowledge, attitudes and preparedness to respond to domestic violence, *Journal of Mental Health* 2013: 22(6):536–543,
14. Goldman HH, Gattozzi AA, Taube CA. Defining and counting the chronically mentally ill. *Hospital and Community Psychiatry*. 1981; 32(1):21–27.

15. Thomas DR. A general inductive approach for analyzing qualitative evaluation data. American journal of evaluation. 2006 Jun; 27(2):237–46.
16. Macy RJ, Ermentrout DM, Johns N. Health care for survivors of partner and sexual violence. In CM Renzetti, JL Edleson, RK Bergen (Eds.), Violence Against Women Sourcebook, *Second Edition*. Thousand Oaks, CA: Sage, 2011, pp. 289–308.
17. Reeves E. A synthesis of the literature on trauma-informed care. Issues in mental health nursing. 2015 Sep 2;36(9):698–709.
18. Logan TK, Walker R, Cole J, et al. Victimization and substance abuse among women: Contributing factors, interventions, and implications. *Review of General Psychology.* 2002; 6:325–397.
19. Elliott DE, Bjelajac P, Fallot RD, Markoff LS, Reed BG. Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. Journal of Community Psychology. 2005 Jul 1;33(4):461–77.
20. Harris ME, Fallot RD. Using trauma theory to design service systems. Jossey-Bass; 2001.
21. Davidson L, Chinman M, Sells D, et al. Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*. 2006;32:443–450.