

Co-location of specialized mental health services in an intimate partner violence advocacy organization

Medicine, Science and the Law
1–12

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DOI: 10.1177/00258024231195496

journals.sagepub.com/home/msl



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Abstract

Historically, services for intimate partner violence (IPV) survivors predominantly focused on advocacy, resulting in service gaps for IPV survivors who need mental health care. When mental health services are offered, there are several barriers that limit treatment engagement. To address these gaps, a novel, integrated care model, comprised of psychiatrists, clinical psychologists, and social workers were embedded into the five New York City (NYC) Family Justice Centers (FJCs), to provide free co-located mental health care to adult survivors of IPV alongside the existing advocacy, social, and legal services. This article reports on the evaluation of the Health + Hospitals Family Justice Center Mental Health Program (FJCMHP) via: (i) seven focus groups with FJC clients and staff and Health + Hospitals (H+H) clinicians; and (ii) de-identified online surveys completed by 53 FJC clients and 130 FJC staff. Clients reported increased access to care, with 67.2% seeing a mental health clinician within two weeks of a request, and improvement in symptom relief, including sleep, mood, irritability, reduction in thoughts of self-harm, improved relationships with others, especially their children, and improved self-efficacy in parenting skills. Additionally, FJC staff reported satisfaction with the FJCMHP model, and increased understanding of clients' mental health needs. The evaluation results highlight the feasibility and tolerability of integrated mental health services in a non-medical setting. The evaluation also identifies areas for improvement, as well as the strengths of an integrated, multidisciplinary mental health service program for IPV survivors co-located in a non-medical, advocacy setting.

Keywords

Legal system, forensic psychiatry

Introduction

Intimate partner violence (IPV) is defined as physical, sexual, psychological, and social violence, including physical aggression, sexual coercion, psychological abuse, verbal abuse, coercive control, and control of economic resources and social relationships, by a current or former partner. The World Health Organization describes IPV as a global health problem of epidemic proportions, with one in three women (around 736 million) subjected to physical or sexual violence by an intimate partner.^{1,2} In the US, approximately one in three women and one in four men have been a victim of rape, sexual violence, or stalking.³ However, women are far more likely than men to experience severe sexual and physical violence from a partner or be killed by one.^{3–5} Approximately half of all women have experienced psychological aggression by an intimate partner,^{5,6} and women are six times more likely to be killed by a partner compared to men, echoing gender-based violence disparities in IPV prevalence rates.²

IPV is frequently the cause of physical injury and sometimes death, as well as psychiatric disorders, including depression, anxiety, post-traumatic stress, substance use

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disorder, and suicidality.⁷⁻⁹ About 30% of adult women who experience IPV reported “serious psychological distress”—much higher than the 7% prevalence among women who reported no experience of IPV.^{9,10} A study based on a representative US sample of more than 25,000 adults indicated that new onsets of major mental health problems were more than twice as common among those exposed to IPV in the past year than among those unexposed to these experiences.¹¹

While the psychological impact of IPV is increasingly recognized, its treatment is challenging. Survivors rarely self-identify or seek mental health treatment—shame, guilt, and denial are deterrents,¹² as is the stigma of IPV.¹³ There are also urgent “practical” contributory factors to the lack of self-reporting, including personal safety, economic dependence, and concerns that disclosure will trigger social service agency engagement, particularly child protection.¹⁴ While 85% of IPV survivors presenting to advocacy organizations in the United States report at least one mental health problem, only one-third have seen a mental health professional during the past year, with 70% reporting at least one barrier to care.¹⁵ The underutilization of mental health services among individuals affected by IPV is even more pronounced in communities that are marginalized due to systemic racism and discrimination and who also seek help from various formal and informal avenues of support.¹⁶⁻¹⁹ In addition, clinicians may feel ill-prepared to manage IPV without specific training on interventions for threats of bodily harm or death and knowledge of community referral resources for relevant legal and ethical obligations.²⁰ There is also a lack of professional literature focusing on psychotherapy for women experiencing IPV.^{21,22}

Historically, interventions for IPV survivors have focused on advocacy for physical safety and financial support rather than psychiatric and psychotherapeutic interventions. For example, services for IPV survivors provide support for immediate removal from exposure to violence and securing safety (e.g. shelter programs, legal advocacy, and economic assistance).¹² Despite calls for mental health services to forge stronger relationships with IPV advocacy services,²³ there is little guidance as to how this might be successfully achieved.

Given the complexity of mental health symptoms common among IPV survivors and that the experience of sexual IPV is associated with more severe mental health symptoms,⁹ highly trained clinicians, such as psychiatrists, clinical psychologists, and social workers, are often necessary to adequately address these problems therapeutically and psychopharmacologically. A recommended best practice to aid a particular population with overlapping but siloed treatment interventions is to promote collaborative care, which has been shown to be effective in augmenting community access to, and use of, mental health services in other settings, such as with the integration of

primary care and mental health services²⁴⁻²⁶ or the development of multidisciplinary sexual assault centers in the Netherlands.²⁷

In recognition of the prevalence of psychological disorders among IPV survivors and the challenges to obtaining tailored mental healthcare, several New York City (NYC) organizations—NYC Health + Hospitals (H+H), the largest public health system in the United States; the Mayor’s Office to End Domestic and Gender-Based Violence (ENDGBV) that operates the Family Justice Centers (FJCs), which bring together advocacy organizations to provide free, onsite social and legal services; and the NYC Office of Community Mental Health (OCMH), a program spearheaded by former NYC First Lady Chirlane McCray to bring mental health services to the NYC community—partnered to create an integrated, multidisciplinary, collaborative care program now known as the NYC H+H Family Justice Center Mental Health Program (FJCMHP).

This article summarizes findings from the program evaluation, which included (a) three focus groups with FJC clients and four focus groups with FJC staff and embedded FJCMHP H+H clinicians and (b) mixed methods surveys completed by 53 FJC clients and 130 FJC staff. The FJC clients included in the study received mental health services provided by the embedded FJCMHP H+H clinicians at the FJCs, located in each of NYC’s five boroughs. The data was collected in July 2018 following the embedding of FJCMHP in the five FJCs on a rolling basis from January to November 2017. The findings are discussed with a view toward (a) improving the understanding of IPV survivors’ mental health needs, (b) increasing the knowledge and awareness of mental health topics relevant for FJC staff, and (c) determining the factors contributing to feasibility and tolerability of implementing co-located specialized mental health services within a non-medical IPV advocacy organization.

The Family Justice Center Mental Health Program

The FJCMHP initially began as a pilot within one of the FJCs as a collaboration between the Columbia University Irving Medical Center (CUIMC), ENDGBV, and the Chapman Perelman Foundation. The pilot collaboration marked the first time that psychiatrists, along with clinical psychologists and social workers, trained in IPV were embedded in an FJC. In 2017, the City of New York expanded the pilot program, under NYC OCMH, to include the FJCs in all five NYC boroughs with mental health clinical services provided by H+H (the program is now officially called the FJCMHP).

The co-location of integrated, multidisciplinary, collaborative mental healthcare was implemented with the goal of addressing existing barriers to mental health access (see Figure 1). Initial needs assessments with the FJCs identified numerous such barriers, including lack of insurance, fear of deportation for the undocumented, lack of

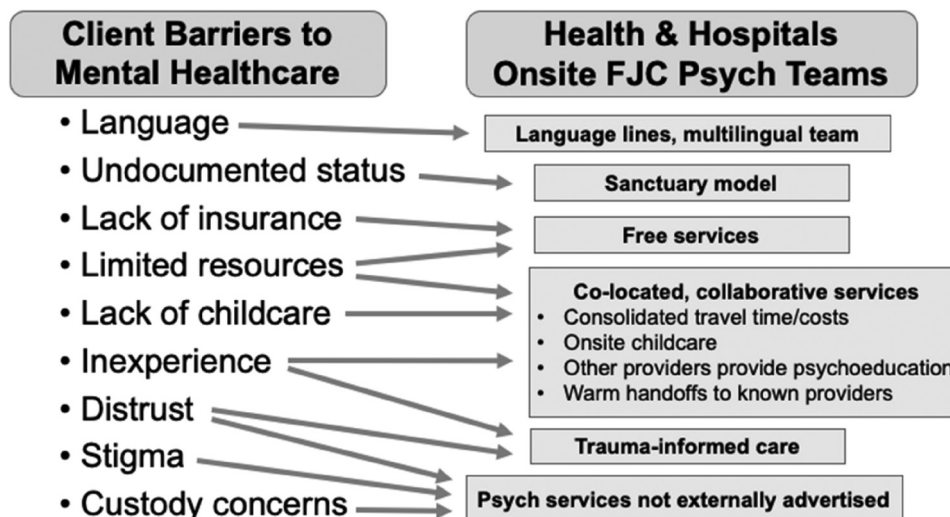


Figure 1. Addressing client barriers to accessing mental healthcare by the H+H Family Justice Center Mental Health Collaboration.

multilingual provider teams, stigma, discomfort in seeking services at locations that may not be physically safe, lack of trust based on prior experience with mental health service providers, geographic distance resulting in significant travel time and expense, lack of child care, fear of engagement of social service agencies possibly resulting in family separation, lack of mental health training provided to non-medical staff, and lack of non-medical IPV training provided to mental healthcare clinicians. FJCMHP was designed to tackle these barriers (see Figure 1) by offering free appointments regardless of documentation status, bilingual (English and Spanish) clinician teams and live translation in over 140 other languages, onsite child care, consolidation of travel time and related expenses, client education about mental health self-care, and stigma reduction and normalization of mental healthcare by providing mental health services onsite in a location already familiar to, and trusted by, clients. A primary goal of FJCMHP was to provide a positive experience in accessing mental healthcare by facilitating a warm handoff from an already trusted, familiar FJC case manager to a specific FJCMHP provider whom the case manager could endorse.

Once implemented across all five boroughs in 2017, each of the five FJCs was staffed with one part-time psychiatrist, one full-time psychologist or licensed social worker to provide psychotherapy, and one full-time administrator. All services were provided at no charge. Services provided by FJCMHP included an initial evaluation using DSM-5 diagnoses and criteria, voluntary referral for psychopharmacologic management when appropriate, and individual and group psychotherapy. Treatment focused on short- and intermediate-term treatment of three- to six-month duration. Clients who were evaluated to require long-term treatment and/or additional services were referred to an appropriate H+H site for ongoing care. FJCMHP also

provided regular educational activities and relevant trainings for FJC staff. These trainings included topics such as Mental Health 101, Trauma-Informed Care, Vicarious Trauma, Grounding and De-Escalation, and Suicide Assessment. FJCMHP clinicians also received training and supervision in various evidence-based treatment interventions, including Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Cognitive Processing Therapy for PTSD (CPT-PTSD), Interpersonal Psychotherapy (IPT), Acceptance and Commitment Therapy (ACT), Eye Movement Desensitization Therapy (EMDR), Risking Connections, Seeking Safety, and Skills Training in Affective and Interpersonal Regulation (STAIR). Furthermore, the FJCMHP multidisciplinary, integrated model allowed for bi-directional learning—the FJCMHP clinicians trained FJC staff in mental health topics, while the FJC staff trained the FJCMHP clinicians in non-medical IPV-related topics.

Methodology

Overview of methodology of the initial mixed methods program evaluation

Data for this study were collected using a quasi-mixed methods design implemented in July 2018 by the CUIMC team for the purpose of evaluating the initial transition and expansion of the pilot model to the H+H program in all five NYC FJCs. The hybrid implementation-effectiveness protocol was reviewed by the New York State Psychiatric Institute (NYSPI) Institutional Review Board (IRB) and was deemed to be a program evaluation and therefore exempt from additional IRB surveillance and requirements. Surveys were administered to individual FJC clients and staff, including co-located partner agency staff (referred to

together with FJC staff as “FJC staff”) who were employees of non-profit and social service agencies. FJC staff included case managers, peer advocates, childcare workers, civil legal service providers, immigration legal service providers, housing legal service providers, the NYPD Sheriff’s Office, and NYC District Attorney’s Office of Victim Services Units in all five boroughs. Focus groups were conducted with FJC clients and staff to obtain additional qualitative measures of the program. A community-based participatory research (CBPR) approach was used to gather and reflect the most relevant questions for FJC clients and staff and other stakeholders involved in the program, including FJC executive directors, FJC IPV survivor clients, and ENDGBV staff.

Inclusion criteria

The FJC IPV client population included in the study were adult English and Spanish speakers aged 18–65 voluntarily seeking mental health services at the FJCs. The FJC staff populations included in the study were adult full-time and part-time employees of FJC and partner agencies. As the FJCs provide social, legal, and supportive services for IPV survivors, staff roles, training, and time commitments varied widely.

Confidentiality

Confidentiality was a cornerstone of the evaluative process in recognition of the potential risks to clients, including the compounding stigma surrounding IPV and accessing mental healthcare, engagement of social service agencies, and retaliation from former or current abusive partners. Neither the surveys nor focus groups collected any identifying information from clients or staff. The surveys explicitly included language to inform respondents that all information would be de-identified. The focus groups were audio recorded, and participants were informed at the start of each focus group that participant demographics and other identifying characteristics would not be recorded. Verbal consent was obtained from each participant prior to the start of each focus group. Focus group interviews for FJC clients and staff were conducted in-person in private rooms at the FJC sites and lasted 2 h. Focus groups conducted in Spanish were later translated into English using an external translation agency. Recruitment of participants for the surveys and focus groups was done via email, announcements at staff meetings, and distribution of flyers onsite at the FJC centers.

Program evaluation phase one: mixed methods approach

The first phase of the program evaluation consisted of two de-identified surveys, available online and in paper, sent to

FJC staff and clients to assess their respective perceptions of the program and client mental health needs.

FJC client survey. An anonymous, voluntary 18-item survey was administered in English and Spanish to FJC clients in July 2018. FJC clients were asked to rate their satisfaction with FJCMHP, their perception of changes in their life having accessed FJCMHP mental health services, and their prior barriers to seeking mental healthcare. For a full list of survey questions, please see Supplemental Section A. Of the FJC clients invited to complete the surveys, 85.4% (53 of 62) participated. The nine who declined to participate did not differ demographically from those who did. The survey first collected demographic information, including client age, race, ethnicity, identification of the most frequently used FJC site, and duration of utilization of FJC services. Age was limited to categories for additional confidentiality. Fifteen of the 18 questions were on a 7-point Likert scale; the remaining three questions were qualitative.

FJC staff survey. An anonymous, voluntary 33-item online survey was administered to FJC staff. For a full list of questions, please see Supplemental Section B. Of the FJC staff invited to complete electronic surveys, 45.0% (130/286) participated. FJC staff ($n = 130$) responded to the survey across all five FJC sites as follows: 32.5% from Queens, 21.6% from Bronx, 18.7% from Manhattan, 16.7% from Brooklyn, and 12.5% from Staten Island. The staff survey was designed to closely follow the initial baseline survey that was administered to FJC staff in 2014 as part of the pilot program to assess for changes in staff behavior, attitudes, and self-efficacy. The survey asked FJC staff to assess the FJC client population in terms of severity of unaddressed mental health risks (including perceived risks of suicidality), substance use, and harm to self or others. The survey also asked FJC staff to assess their perception of their own ability to identify mental health problems, knowledge of appropriate community referrals, and belief about the effectiveness of available mental health services. Twenty-nine of the 33 questions were on a 5- or 7-point Likert scale; the remaining four questions were qualitative.

Program evaluation phase two: qualitative approach

The second phase included a series of focus groups with FJC staff and clients conducted by the principal investigator to elicit participants’ experiences and perspectives regarding efficacy of FJCMHP for IPV survivors.

Focus group methodology

Interviews for FJC clients and staff were semi-structured, qualitative, and responsive to client and staff to provide

opportunity for exploration. Questions addressed the intersection between mental health and IPV, treatment prior to the co-location of FJCMHP at the FJCs, and use of FJCMHP services. For a full list of focus group questions, please see Supplemental Section C. Grounded theory and an inductive approach to thematic analysis were deployed to identify key findings from focus group data. The data was analyzed at both the semantic or explicit level (i.e. focused on the content of participants' statements) and the latent level (i.e. focused on ideas that governed the semantic content of the data). Two investigators (EMF and OOB) read each of the transcripts in their entirety and discussed general impressions and insights they had gained from the focus. Themes were developed with preliminary coding that were then applied to each transcript. Some original codes formed main themes, others formed subthemes, and others were discarded. Doubts or disagreements were resolved by rereading the original transcripts until both investigators agreed. A third investigator (MW) then re-reviewed the transcripts to apply the final coding scheme based on the larger themes. All three investigators met to review and refine the final themes to ensure internal homogeneity and external heterogeneity. Disagreements were resolved by consensus.

Client focus groups. Three client focus groups were conducted—two bilingual English/Spanish focus groups were held at the Bronx and Manhattan FJCs, and one monolingual English focus group was held at the Queens FJC. A Spanish translator was present for focus groups where at least one speaker was predominantly Spanish speaking. FJC clients were offered public transportation cards and light refreshments at focus groups but were not financially compensated for their time. Attendance was not taken to support confidentiality. Groups ranged from 8 to 15 participants. The principal investigator facilitated the focus groups, with a research assistant present to take notes and assist as needed. The focus groups were 2 h long.

FJC staff focus groups. Four FJC staff focus groups were conducted at Staten Island, Brooklyn, Manhattan, and Queens FJCs. FJC staff were offered light refreshments but were not financially compensated for their time. The principal investigator conducted these focus groups in English, with the support of a research assistant. Attendance was not taken in the interests of confidentiality and ranged from 10 to 15 participants. At all FJC staff focus groups, participants were asked the same 12 questions.

Results

Demographics

Client survey demographics. Of the 62 FJC clients invited to complete surveys in English or Spanish, 85.4% ($n=53$)

participated. The median age group was 31–40. In total, 30.2% ($n=16$) identified as White, 17.0% ($n=9$) identified as Black or African American, and 28.3% ($n=15$) responded unknown or do not want to answer. Nearly half of the population identified as Hispanic (47.2%, $n=25$); 54.7% ($n=29$) reported having received non-medical social and/or legal services at their FJC for one to six months. The majority, 62.3% ($n=33$), had not seen a mental health professional prior to arriving at a FJC. Table 1 provides FJC client demographic data.

Staff survey demographics. Of the 286 FJC staff (part-time and full-time), 45.0% ($n=130$) completed the staff survey. The most frequently self-reported role was case manager (29.2%, $n=38$) and legal providers, including civil, immigration, housing law specialists, and representatives from the Municipal District Attorney's Office/

Table 1. Family justice center mental health program client demographics.

	FJC client	
	N	%
Age		
18–25	1	1.9%
26–30	9	17.0%
31–40	25	47.2%
41–50	13	24.5%
>50	5	9.4%
Ethnicity		
Hispanic	25	47.2%
Not Hispanic	23	43.4%
Did not answer	5	9.4%
Race		
White	16	30.2%
Black or African American	9	17.0%
American Indian/Alaskan Native	2	3.8%
More than one race	7	13.2%
Other	4	7.5%
Unknown or do not want to answer	15	28.3%
FJC borough		
Queens	12	22.6%
Bronx	13	24.5%
Brooklyn	9	17.0%
Staten Island	10	18.9%
Manhattan	9	17.0%
How long at FJC		
Less than 1 month	2	3.8%
1–6 months	29	54.7%
7 months–1 year	13	24.5%
1–2 years	8	15.1%
2–4 years	1	1.9%
Seen a mental health professional before		
No	33	62.3%
Yes	19	35.8%
Did not answer	1	1.9%

Victim's Services (29.2%, $n = 38$). The median number of years worked at an FJC was less than one (38.3%, $n = 46$). Staff reported a median caseload of 21–40 clients, with a range of 11 to over 100 clients in a caseload. More than 10 staff members indicated that they carried caseloads of more than 100 clients.

Qualitative results: categories emerging from thematic analyses

Through qualitative analyses, coders converged on six thematic categories: need for access to mental health services, utilization of services, clinical improvement/treatment outcomes, FJC staff training in mental health, and satisfaction, limitations, and areas for growth. For each thematic category, results from surveys and focus groups are reported concurrently.

Mixed methods results grouped by category

The need for access to mental health services. Staff and client survey responses confirmed the need for access to co-located mental healthcare. A majority of surveyed clients (56.8%, $n = 21$) reported that their mental health needs made it difficult to achieve their goals. A majority of staff also viewed their clients' mental health needs as interfering with clients' ability to achieve their goals (74.7%, $n = 56$), the client's ability to increase their own safety (76.0%, $n = 57$), and the staff member's individual ability to assist the client (68.0%, $n = 51$). FJC staff (85.6%, $n = 77$) consistently reported that nearly a quarter of their clients required urgent psychiatric evaluations, with 61.8% of staff reporting that greater than half of their caseload expressed or displayed sadness or despair, 42% of staff reporting that over half of their caseload talked about sleep difficulties or insomnia, and 39.8% of staff reported up to a quarter of their caseload expressed desire to harm themselves and/or reported a history of harming themselves and/or expressed thoughts about suicide.

During a focus group, a client reported seeing clear connections between their experiences of abuse and mental illness:

I think domestic violence and mental health go hand-in-hand because when you are going through it, whether it is physical abuse, words or anything like that, you sometimes don't feel like telling anyone...you feel ashamed because it's something that affects you throughout the whole day 'cause you're living it—it's in your head 24/7 and that affects you...it's something that affects you so much to the point where you start forgetting things...You have to take your kids to school and try not to cry in front of them, you ignore everything to the point where you get sick. (Client 3)

During focus groups, clients reported that their trauma history caused depressive and post-traumatic symptoms,

such as low mood, low self-esteem, low motivation, and avoidance, which, along with the stigma associated with IPV and having a co-occurring mental illness, presented additional barriers to accessing resources. As one client stated:

My friend had to take me here, I didn't come here by myself and I was not going to do anything...My friend took me here so maybe I don't even deserve to be here because I didn't do anything—my friend took me. People tried to help me...I was abused but I still didn't want to move against...it's so hard when you are in the situation it's so hard, like you don't want to wake up. (Client 6)

Similarly, FJC staff who attended focus groups enumerated clients' barriers to mental healthcare. Some of the most frequently mentioned barriers included the stigma associated with IPV and having a co-occurring mental illness, clients' heightened emotional distress, high cost of mental healthcare/lack of insurance, fear of deportation for undocumented IPV survivors, distrust of providers, fear of engagement of social service agencies possibly resulting in family separation, lack of culturally and trauma-informed care, lack of racial and minority healthcare providers, de-prioritization of mental health resulting from habituation to physical danger, difficulty with a transition from crisis-related care to longer-term treatment, and prior medical trauma.

One FJC staff member reported that stigma may be a barrier to care in part because it has been used as a form of emotional abuse:

Our clients, like all of us, live in a society where having mental health issues and seeking help for mental health issues is still stigmatized. So sometimes that can present a challenge, due to personal experiences...past experiences and mental health services within their own communities and cultures around mental health services. And may also have experienced being told by their abusive partner that "You're crazy." (Staff 10)

FJC staff reported that FJCMHP co-located services addressed many of the barriers to care identified earlier. As one staff member said,

I have one client who is getting services because it is mandated through ACS. And she lives far away. She had...a problem with her foot so travelling was really difficult... And first she was going to all these different places...it was really, really complicated for her. So...to get all her services in one location it's been such a drastic change for her...such an improvement. And it's helped her case because she has been more willing to complying to what ACS is mandating...she feels very comfortable and very safe with FJC space. (Staff 31)

Utilization of FJCMHP services. Prior to the availability of FJCMHP services onsite, the majority of FJC staff (43.1%, $n = 28$) reported that it took more than two

months for their clients to access mental health services; some clients could not be connected to care at all. Once FJCMHP services were available onsite, 67.2% ($n=44$) of FJC staff reported that it now took fewer than two weeks to connect clients to onsite mental health services. Survey responses also indicated that the use of FJCMHP services was widespread, with 72% of FJC staff referring up to a quarter of their caseload to FJCMHP. Reasons for delay in connecting to FJCMHP mental health services included the client not being ready to see a mental health professional (30.7%; $n=8$), another 30.7% ($n=8$) citing scheduling conflicts, and 23.1% ($n=6$) stating they were not given an earlier appointment.

Treatment varied, with almost a half of FJC clients who were receiving mental health services onsite engaging in individual psychotherapy alone (43.8%, $n=21$), followed by concurrent medication management and individual psychotherapy (29.2%, $n=14$). Six clients (12.5%) were engaged in medication management, individual therapy, and group therapy. The remaining clients were engaged in medication management or group treatment alone, with some of the remaining group of clients engaged in individual and group therapy without medication management. Both clients and staff cited the importance of being able to refer clients easily and directly without long wait times or complicated logistics.

I think everything is working. I like that when I make an appointment, they see me right away. I set a time and at that time [MH clinician] is there waiting for me. Not like other places, I have friends who go places and they're in the waiting room for hours maybe. (Client 39)

A staff member concurred:

I was actually able to just, like—able to transition out the family like a month or so ago, and they're in a much better place. The kid has not had any symptomatology and, like, mom physically looks so much better and has been doing so much better. Um, and I don't think we would've been able to refer them out anywhere else. (Staff 18)

Clients reported that specific skills to cope with traumatic stress, including grounding and de-escalation skills, were necessary and part of why they continued to use the program. As a client summarized:

I love [FJCMHP Therapist] because she has taught me so many exercises. Now I'm able to...just think to myself it's okay, that's in the past, you're not going to go through that again, don't let yourself go through that again. I feel so good thanks to the therapies that she has given me and everything that she has taught me, she has allowed my mind to open and get all of those frustrations out. (Client 28)

Some clients who had previously accessed external mental health services reported anxiety about receiving

provider advice to adhere to a medication protocol regardless of side effects and/or without consideration of their own treatment and other priorities in ways that felt invalidating. In contrast, FJCMHP clinicians aimed to carefully solicit and address client concerns about medication and promoted clients' agency in their treatment. Staff concurred that working with FJCMHP providers, who practiced patient-centered, trauma-informed approaches that included allowance for IPV survivor clients' sensitivity to issues of power and control, improved their clients' tolerance of psychiatric services:

I had a client who was a little skeptical about meeting with [FJCMHP psychiatrist]. Because psychiatrists freaked her out. And she didn't know—at the time, she was trying to manage her emotions without her medication...And then after meeting with [FJCMHP therapist], who introduced her to [FJCMHP psychiatrist]—she loves her. (Staff 13)

The god's honest truth if it wasn't for [FJCMHP], I wouldn't be here; they saved my life. It was horrible—and it's very hard for me to trust anybody as it is because of my background—but they made me feel so comfortable, and they understood where I was coming from. (Client 2)

Clinical improvement/treatment outcomes. Client survey data revealed self-reported improvements in symptoms, functional improvement, and greater insight into self-care and psychoeducation on mental health and IPV following initiation of mental health treatment with FJCMHP. Clients were asked to rate on a scale of 1–5 how strongly they agreed or disagreed with statements about changes in their symptoms following commencement of FJCMHP mental health services. In total, 51.0% ($n=25$) of clients reported suicidal ideation prior to commencement of FJCMHP services. Of these, 84.0% ($n=21$) agreed or strongly agreed that following access to FJCMHP services, their suicidal ideation had markedly decreased; 97.6% ($n=41$) of clients agreed or strongly agreed that following access to FJCMHP services they achieved increased insight and mental health literacy. Clients overwhelmingly agreed that they achieved functional improvement, with 90.0% ($n=45$) indicating their mood had improved resulting from access to FJCMHP services. Similarly, 73.5% ($n=36$) reported improvement in sleep, and 77.6% ($n=38$) reported lower levels of distress following access to the FJCMHP.

Clients also reported increased improvement in self-efficacy, interpersonal effectiveness, motivation to change, parenting skills, and future orientation following FJCMHP services. Of 45 clients who responded to questions about experiences following accessing FJCMHP mental health services, 93.3% ($n=42$) reported improvement in their ability to follow through on tasks; 80.1% ($n=21$) reported improvement in their relationships with significant others; 85.7% ($n=30$) of clients reported

improvement in relationships with family and friends; 92.3% ($n=24$) reported improvement in their relationships with their children; and 97.1% ($n=44$) reported that their relationships with FJC staff improved (see Figure 2).

FJC staff also reported improvement in outcomes with their clients following access to FJCMHP services: 65.8% ($n=48$) of staff reported noting clients' increased efficacy; 63.9% ($n=46$) reported observing clients' increased capacity to complete tasks (e.g. attending appointments such as court dates and doctor's appointments, obtaining U-visas, and reporting to work); 62.2% ($n=46$) reported that their clients' distress had decreased; and 62.2% ($n=46$) reported that their clients' suicidal ideation had decreased (see Figure 3).

Yeah, I'm noticing now I get up, I'll take a shower, I'll cook, I'll clean. I'm starting to become that person that I was without him, before I meet him, and I feel strong. (Client 15)

During the focus groups, clients reported that accessing mental health services with FJCMHP increased their awareness of their participation in behavioral patterns associated with cycles of IPV.

In my case, with my partner, there were negative connotations to therapy, as being weak. Now I go to therapy and I have no shame, it's been helpful. Therapy has allowed me to look into that, make me ask why I keep doing it. See what in my past makes me repeat this. (Client 45)

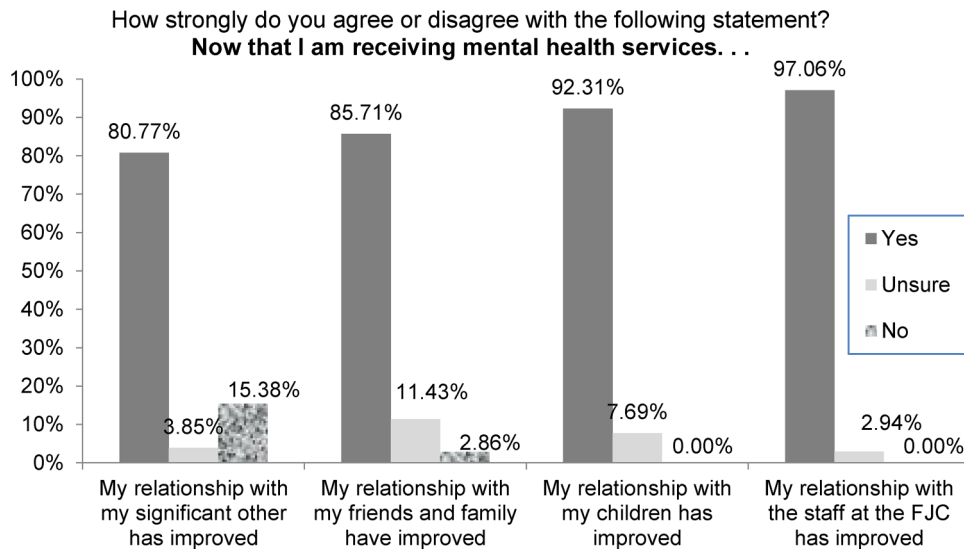


Figure 2. Clients' self-reported functional improvements attributed to H+H Family Justice Center Mental Health Collaboration.

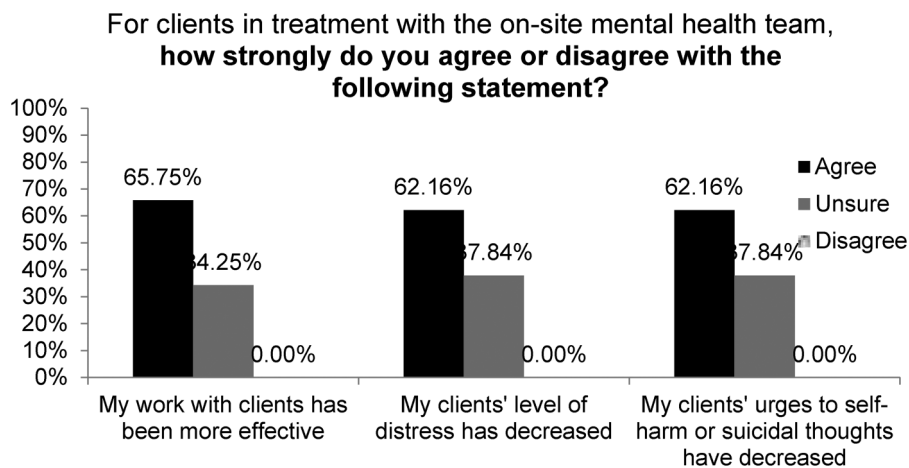


Figure 3. Family Justice Center staff report of functional improvement attributed to the H+H Family Justice Center Mental Health Collaboration.

Clients often reported that they felt that their children, regardless of age, were benefiting from their improved mental health, as it translated into more sensitive parenting:

I have a son that is almost 22. [FJCMHP clinician has] helped me a lot to be patient with him, to be even nice with him because before I sometimes go to strike... And now I can speak with him about how he has to treat his girlfriend. How violence is psychology and it's not only the people they hit you or something like that. (Client 11)

I am now 7 months into being a single mother, and I'm starting to get comfortable in the role. My self-worth is often tied to my son and how I interact with him. But therapy has definitely helped. I see myself being more patient, not having short outbursts, instead dealing with things productively, a step at a time. I think it has definitely changed things. I am different with him. I am working on my feelings about being a mother. (Client 8)

FJC staff training in mental health. FJC staff reported improvements in their self-efficacy in identifying and evaluating clients' mental health needs. Staff also reported satisfaction with the FJCMHP model, including the services offered to their clients, psychoeducation programs offered to staff, and their collaborative relationship with FJCMHP. Staff reported significant improvement in their abilities to function in their respective roles to connect clients to mental healthcare, with 58.1% ($n = 54$) reporting improvement in their ability to recognize which clients need referrals for mental health services. Similarly, 47.3% ($n = 44$) of surveyed FJC staff reported improvements in their ability to inquire about psychosis and paranoia, and 45.2% ($n = 42$) reported improved capacity to inquire about suicide.

In focus groups, staff reported overcoming stigmatized representations of mental illness:

I am learning to recognize some of the mental health problems that do exist...Now I have this conversation and get out of my comfort zone, to ask about and be aware of mental health. (Staff 22)

At times, staff reported feeling emotionally overwhelmed by clients' experiences and found the support of FJCMHP useful for themselves:

They've given us coping mechanisms. Like I could go to, like let's say I'm going through vicarious trauma. I can say, [FJCMHP therapist], I'm feeling really overwhelmed today because you know, it's been a long week and I worked with this client and she really...Affected me and she'll sit and...give me some techniques and tools and say this is what you can do moving forward, and let me know how that works. (Staff 8)

Staff also reported reduction in stress due to shared responsibility with FJCMHP for their clients' wellbeing:

And I really think just as a case manager...I don't have it in my mind all night. Like, oh my God, like what is going to happen to his client next week? Oh, my God the court date is next week, this client has like PTSD...So, it kind of like takes off a little bit of the weight off my shoulders to know that I passed her on to a professional who's going to be talking to her. (Staff 47)

Satisfaction. Clients overwhelmingly expressed satisfaction with the mental health services provided by FJCMHP, including near universal satisfaction with their mental health needs being met (100.0%, $n = 49$), FJCMHP's professionalism (97.7%, $n = 48$), wait time prior to being seen by the FJCMHP (95.8%, $n = 46$), communication and coordination of their care by FJCMHP administrative staff (100.0%, $n = 49$), and the quality of care they received (100.0%, $n = 49$).

The overwhelming majority of FJC staff (73.6%, $n = 67$) strongly agreed that they were satisfied with the quality and professionalism of the mental health services provided by FJCMHP. The majority also strongly indicated that they were satisfied (65.1%, $n = 56$) with the mental health trainings they received.

The supportive relationship fostered by FJCMHP created stronger client connections and made FJCMHP valuable to the clients as an aid to healing and recovery:

When [FJCMHP clinician] writes down my appointment like let's say, "Okay I'll see you next week," and she's writing that down and I keep it—I keep it. I look at it. I always keep that I collected all of them because that give me; like this is about me, she is so important to me. (Client 31)

Limitations and areas for growth in implementation practices.

FJC staff responses in focus groups and to open-ended survey questions indicated several challenges presented by the integration of mental health services into a non-medical/advocacy setting. Reported challenges reflected the need for ongoing communication and transparency regarding referral pathways to FJCMHP and sharing of client information. Among FJCMHP H+H clinicians who participated in focus groups, concerns raised included additional time demands in responding to high intensity cases, the duality of supporting FJC clients and staff, limited existing models for collaborative care, and complexity of cases involving legal and forensic agency involvement.

A key area of improvement identified by both clients and FJC staff was increased availability of IPV-trained clinicians. Clients in focus groups emphasized a desire for

more treatment options, including more groups, more access to FJCMHP H+H clinicians, and more flexibility in treatment hours, especially drop-in hours and after-work hours.

I do wish we had the chance to ask for other appointments, for a sooner appointment, for access to the providers' schedule and greater flexibility so that you could meet with someone sooner rather than waiting until the following week. (Client 22)

Staff pointed out that there was incredibly high demand for mental health services, and not everyone who might benefit from assessment or treatment was seen.

There are no negatives, except that there are not enough mental health professionals to meet the demands. (Staff 21)

FJC staff also reported the need for more guidance about the referral process to FJCMHP, including what clients should expect, and how psychotherapy supports mental health and recovery from IPV. Many FJC staff expressed uncertainty about the nature of mental health treatment options offered by FJCMHP and found the language used to describe those options opaque.

The word "counseling" is such a broad term. Like, a lot of people can do counseling and not even have like, you know, a, a license. So, it's kind of like explaining exactly what, what they're, what kind of, what the session's going to be like, how it's going to help them. (Staff 28)

Discussion

IPV survivors present with urgent needs for mental health services; however, gaps remain as to how best to respond.⁹ This report supports the FJCMHP model—a novel collaboration between New York City's public hospital system, city government, and non-profit, non-medical partner advocacy organizations—as a useful prototype of a system for responding to IPV survivors' mental health needs. Findings presented here describe our program evaluation to examine the value of an integrated, multidisciplinary, collaborative care specialty model that co-locates evidence-based mental health services in a non-medical setting.

Based on this hybrid qualitative and quantitative evaluative approach, FJC clients and staff reported that FJCMHP is meeting IPV survivors where they are and where they feel the safest. The results highlight that FJC clients reported feeling physically and emotionally safe accessing mental healthcare at the FJCs. FJC clients also reported experiencing improvements in sleep and mood, reduction in anxiety and psychological distress, and

improvement in interpersonal relationships and parenting skills. Another key component of co-locating mental health services at the FJCs was a marked reduction in wait and travel times for FJC clients to access care, which diminished a critical barrier accessing care for FJC clients while also improving FJC staff morale and ability to provide services in their respective roles. Although children living with IPV survivors were not the focus of the evaluation, FJC clients reported that they felt their children were also benefiting from their participation in FJCMHP as a result of their improved mental health and awareness of the impact of IPV and its sequelae on their parenting skills.

The evaluation also demonstrated that the integration of mental health clinicians trained in IPV encouraged ongoing and continual discussion and reflection among FJC staff around the mental health impacts of trauma. FJC staff repeatedly reported improved knowledge of mental health concerns exhibited by their clients, application of knowledge to their cases, support in their work from onsite FJCMHP clinicians, and a better understanding of vicarious trauma. The bi-directional education model used—in this case, FJCMHP staff learning about supporting survivors of IPV with non-medical interventions (e.g. case management and IPV safety planning) and FJC staff learning about assessing and addressing mental health concerns—helped to break down the stigma associated with both mental health and IPV and change the culture of an historically non-medical advocacy organization.

Strengths of the evaluation methodology include a relatively large sample size of clients ($n=53$ for survey and approximately 45 for focus groups) and FJC staff ($n=130$ surveys and approximately 55 for focus groups) and layers of review and consensus building where results of the evaluation were shared with FJC staff and FJC leadership. The inclusion of both FJC clients and staff yielded rich information that strengthened the findings of each group; however, despite the adequate sample size, evaluation findings may not be equivalent to other settings or populations as the evaluation was based solely on a selected group of IPV survivors who sought and followed through with accessing mental healthcare. Further evaluation is warranted to screen IPV survivors who have not yet self-identified as requiring mental health services and assess whether mental health services for IPV survivors is provided equitably across minoritized groups, including racial, sexual orientation, gender identity, and other demographic groups.

There were several limitations to the evaluation methodology. Results were based on client symptom reporting rather than standardized assessment measures and were not verified through clinical interviews due to confidentiality considerations. Future research would benefit from using clinician-administered assessments of pre-and post-change in DSM-5 symptom improvement and a comparative study

with a control group of IPV survivors not engaged in mental health treatment. Additional areas for research include longitudinal evaluation of the medium- and long-term impact of mental healthcare for adult IPV survivors; medium- and long-term benefits in mental health and psychosocial development of survivors' children; sustained benefits to FJC staff, including decreased rates of staff burnout and turnover; and best practices for a call to action for this population during increased periods of stress, such as the COVID-19 pandemic.

The evaluation results show the value of quality, trauma-informed mental healthcare embedded in a trusted advocacy center in partnership with community-based organizations with a shared goal of reducing the stigma surrounding seeking mental healthcare for IPV and highlighting the preventable and treatable nature of mental health disorders. We suggest that the implementation of integrated, co-located, collaborative care services like the FJCMHP model can result in increased use of effective clinical resources directed to this high need and critically underserved population of IPV survivors.


Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the American Academy of Child and Adolescent Psychiatry, Chapman Pearlman Foundation (grant number Pilot Award, Career Development Award).

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Supplemental material

Supplemental material for this article is available online.

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