MIDD Briefing Paper

ES 13a Domestic Violence/Mental Health Services and System Coordination

Existing MIDD Program/Strategy Review ☒ MIDD I Strategy Number: 13a **(Attach MIDD I pages)**
New Concept ☐ (Attach New Concept Form)
Type of category: Existing Program/Strategy EXPANSION

SUMMARY: This existing MIDD Strategy co-locates a 0.8 FTE Licensed Mental Health Professional (MHP) with expertise in domestic violence (DV) and substance use disorders at each of four community-based domestic violence victim advocacy programs around King County. In addition to the collaboration and coordination that currently exists within the Domestic Violence response network, this strategy also currently provides a 0.8 FTE Systems Coordinator/Trainer to coordinate ongoing cross training, policy development, and consultation on DV and related issues between mental health, substance abuse, sexual assault and DV agencies throughout King County. The Systems Coordinator offers training, consultation, relationship-building, research, policy and practice recommendations, etc. for clinicians and agencies who wish to improve their response to survivors with behavioral health concerns. Expansion efforts to fund additional DV community-based agencies to provide a co-located MH clinician is included in this briefing paper, with a focus on including additional agencies who provide specialized services to marginalized populations (i.e. people of color, refugee/immigrants, LGBTQ, etc.).

Collaborators:

Name	Department
Daisy Lau-Leung	DCHS/MHCADSD
Linda Wells	DCHS/CSD
Pat Lemus	DCHS/CSD
Lisa Kimmerly (MIDD Evaluator)	DCHS/MHCADSD
Chris Verschuyl	DCHS/MHCADSD

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Peg Coleman	Executive Director	Domestic Abuse Women's Network (DAWN)
Susan Segall	Executive Director	New Beginnings
Alicia Glenwell	Systems Coordinator	Coalition Ending Gender Based Violence
Nancy Boyle	Program Manager	Domestic Abuse Women's Network (DAWN)
Maria Williams	Program Director	LifeWire
Liz Santiago	Program Director	New Beginnings
Beverley Chase	MH Therapist	New Beginnings
Merril Cousin	Executive Director	Coalition Ending Gender Based Violence
Carlin Yoophum	Program Director	Refugee Women's Alliance

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New**

Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

This existing MIDD Strategy co-locates a 0.8 FTE Licensed Mental Health Professional (MHP) with expertise in domestic violence (DV) and substance use disorders at each of four community-based domestic violence victim advocacy programs around King County. One of the four agencies is an agency specializing in the provision of services to immigrant and refugee survivors of DV. Services provided by the mental health professional include the following:

- Screening using the Global Assessment of Individual Need – Short Screener (GAIN-SS)
- Assessment
- Brief therapy and mental health support, both individually and in group
- Referral to mental health and substance use disorder treatment for those DV survivors who need more intensive services
- Consultation to DV advocacy staff and staff of community mental health or substance use treatment agencies

In addition to the collaboration and coordination that currently exists within the Domestic Violence response network, this strategy also currently provides a 0.8 FTE Systems Coordinator/Trainer to coordinate ongoing cross training, policy development, and consultation on DV and related issues between mental health, substance abuse, sexual assault and DV agencies throughout King County. The Systems Coordinator offers training, consultation, relationship-building, research, policy and practice recommendations, etc. for clinicians and agencies who wish to improve their response to survivors with behavioral health concerns.

The target population for this strategy is adult DV survivors who are experiencing mental health and substance use concerns (as evidenced by screening using the GAIN-SS) that are determined to need access to early intervention services and prevention of severe mental health and substance abuse.

According to the demographic information collected by the MIDD evaluation team, this strategy served over 2,000 unduplicated (2,030) individuals from February of 2009 through September of 2014.

Overall program/strategy goals include the following:

- To promote a reduction in the incidence and severity of substance abuse, mental and emotional disorders in youth and adults.
- To integrate mental health services within community-based domestic violence agencies, including training and consultation for advocacy and other staff, making services more accessible to domestic violence survivors.
- To improve screening, referral, coordination, and collaboration between mental health, substance use disorder, domestic violence, and sexual assault service providers.

The current system for integrated MH services within DV agencies is already over capacity. Expansion efforts to fund additional DV community-based agencies to provide a co-located MH clinician is included in this briefing paper, with a focus on including additional agencies who provide specialized services to marginalized populations (i.e. people of color, refugee/immigrants, LGBTQ, etc.).

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☐ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☐ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

Strategy 13a fits most predominantly within the Prevention and Early Intervention strategy area, as in most cases, the brief mental health intervention is designed to identify and address mental health needs with DV survivors early, in hopes of reducing the risk for developing more severe trauma-related health or mental health conditions.

This strategy also addresses the Systems Improvements area, as it is designed to improve access to mental health and substance use treatment for domestic violence survivors with clinicians who also have a better understanding of the effects of domestic violence and other forms of trauma (which frequently co-exist) on survivors' mental health. There is some evidence to suggest that survivors feel more comfortable/confident and are more successful in addressing their mental health issues when they feel the unique issues and challenges associated with being a DV survivor are better understood.

Strategy 13a also touches on the crisis diversion/recovery and re-entry strategy areas, as individuals presenting to DV agencies for services are often in immediate crisis. Though this is not the focus of their role, clinicians located in DV agencies often work with DV advocates to help stabilize individuals in crisis and connect them to the resources needed to successfully reintegrate back into the community.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

The National Intimate Partner and Sexual Violence Survey (NISVS) is a nationally representative survey conducted by the Centers for Disease Control that assesses experiences of sexual violence, stalking, and intimate partner violence among adult women and men in the United States. The most recent 2010 report indicates the following statistics:

- Nationally:
  - One in four women (22.3%) has been the victim of severe physical violence by an intimate partner.
  - The percentage of women who considered their physical or mental health to be poor was almost three times higher among women with a history of violence compared to women who have not experienced these forms of violence.
  - Analyses of 2010 NISVS data suggest that nearly half of female victims and approximately two thirds of male victims who indicated a need for services did not receive any of the services needed as a result of intimate partner violence experienced during their lifetimes.
- Washington State:

    - An estimated 42.6 percent of WA State women have a lifetime incidence of rape, physical violence, and/or stalking by an intimate partner; this translates to approximately 1,094,000 victims.
- Though the NISVS did not include county-level data, the report's findings can be used to estimate need in King County:
    - The United States Census reports that there were 2,079,967 people residing in King County in 2014, 1,039,984 (50.0%) of whom were female.
    - Using the most recent data available from the 2010 NISVS, we can estimate that 443,033 (42.6% of 1,039,984 female King County residents) women in King County have experienced rape, physical violence and/or stalking by an intimate partner in their lifetime, and that 231,916 (22.3% of 1,039,984 female residents) have experienced severe violence.

The National Network to End Domestic Violence (NNEDV) conducted its 2014 annual "24 hour Census of Domestic Violence Shelters and Services" which documented 1,930 victims served in one day in Washington State; 1,026 of whom found refuge in emergency shelters or transitional housing and 904 received advocacy services other than shelter, including individual support and counseling, legal advocacy, help finding or retaining housing and children's support groups.[1] This same report indicates that during the same day long count, there were 549 unmet requests for services.

Intimate partner violence (IPV) is associated with a range of trauma-related health and mental health effects. Research conducted over the past 30 years has consistently demonstrated that being victimized by an intimate partner increases one's risk for developing depression, PTSD, substance abuse and suicidality as well as a range of chronic health conditions.[2] Reviews of the literature support this with the following statistics:

- Compared to women who have not experienced IPV, survivors have nearly double the risk for developing depressive symptoms, and three times the risk for developing major depressive disorder. [3]
- Women exposed to IPV are up to three times more likely to engage in deliberate self-harm.[4]
- Women who reported partner violence at least once in their lifetime are nearly three times as likely to have suicidal thoughts and four times as likely to attempt suicide.[5]

There is significant evidence that people from marginalized communities are at significantly higher risk for experiencing domestic violence, and also suffer greater impacts from the abuse they face.

[1] NNEDV 2014 Domestic Violence Counts: A 24-Hour Census of Domestic Violence Shelters and Services

[2] National Center on Domestic Violence, Trauma & Mental Health 2014 Fact Sheet entitled *Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness*

[3] Beydoun, H.A., Beydoun, M.A., Kaufman, J.S., Lo, B, Zonderman, A.B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: A systematic review and meta-analysis. Social Science & Medicine, 75(6), 959-975.

[4] Boyle, A., Jones, P., Lloyd, S. (2006). The association between domestic violence and self-harm in emergency medicine patients. Emergency Medicine Journal, 23, 604–607.

[5] Ellsberg, M., Jansen, H.A., Heise, L., Watts, C.H., Garcia-Moreno C; WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health & domestic violence: An observational study. Lancet, 371(9619), 1165-1172.

- The NISVS study cited above found that prevalence rates for domestic violence varied between racial and ethnic groups, with Black non-Hispanic women (43.7%), American Indian/Alaska Native women (46.0%), multiracial non-Hispanic women (53.8%) having the highest rates.
- More than four in 10 lesbian women (43.8%), six in 10 bisexual women (61.1%), as compared to one in three heterosexual women (35.0%) experienced partner abuse.
- Women and men who experienced food or housing insecurity in the past 12 months were more likely to report partner violence compared to those who did not experience these problems.
- The Washington State Domestic Violence Fatality Review (http://dvfatalityreview.org/) found that immigrant women and Native American/Alaskan Native women are at higher risk of homicide by intimate partners, with the rate of domestic violence homicide for Native women in Washington State being 2.8 times higher than for white, Non-Hispanic women.

As described above, there is growing recognition that domestic violence can have serious mental health consequences, yet the systems to which women turn are frequently unprepared to respond to these needs. There has been no systematic response to domestic violence within the mental health system. Nor have domestic violence advocates developed consistent strategies for addressing the mental health consequences of abuse or the needs of women dealing with mental illness and abuse. This leaves large numbers of women and children without a safe way to address these concerns.[6]

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

As described above, survivors of domestic violence are at greater risk of developing a variety of mental health disorders, including depression, anxiety and PTSD. Survivors are often in an environment of on-going trauma, which can prolong and exacerbate their mental health concerns, increase their vulnerability and compromise their safety. Strategy 13a's model of early, accessible mental health intervention combined with integrated advocacy and other supportive services decreases the risk of mental health concerns and other negative impacts of domestic violence and increases survivor stability and capacity to cope. Strategy 13a decreases barriers for survivors by identifying areas of concern (screening), providing trauma-informed therapy integrated with advocacy, and facilitating referrals to other appropriate MH and/or CD support.

Strategy 13a's services are more accessible, appropriate and effective for many DV survivors than other existing mental health service options in King County.

- Strategy 13a enables survivors of DV without Medicaid, insurance, or private means of payment to access trauma-informed services that are specific to their MH and safety needs.
- The MHPs in Strategy 13a have expertise in providing trauma-informed, DV-appropriate services that reduce safety concerns and other negative implications of accessing MH services.
- Strategy 13a's services are culturally and linguistically appropriate for many refugee and immigrant communities; many services at community and private MH organizations are not.
- Many DV and SA survivors are heavily involved in criminal and/or civil legal proceedings related to their experience. Community and private MH providers are often not familiar with these issues and are less able to help survivors navigate the often confusing, intimidating legal system.
- The DV agencies offer MH services as part of a unique, comprehensive package of holistic services that speak to the specific needs of DV survivors.

[6] Carole Warshaw, Ada Mary Gugenhiem, Gabirela Morney and Holly Barnes. Fragmented Services, Unmet Needs: Building Collaboration Between the Mental Health and Domestic Violence Communities. Health Affairs, 22, no.5 (2003): 230-234.

Training and consultation coordinated by the Coalition's Systems Coordinator also increases the capacity of the advocates at participating DV agencies and clinicians at King County community MH and CD programs to identify, understand and respond to survivors' mental health concerns. It fosters collaboration and coordination between and among victim advocacy and behavioral health programs, and coordinates systems change efforts across these sectors.

The proposal to expand strategy 13a to provide co-located therapists in more agencies will directly help meet the disproportionate need in marginalized communities, and will promote King County's race and social justice agenda. All of the DV service providers that have identified the need for, and capacity to implement, this strategy for their clients serve culturally marginalized communities and/or underserved regions of King County.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

MIDD annual evaluation data suggests that over the six year evaluation period of this strategy to date, program successes supporting improved access to mental health services for DV survivors include:

- Universal screenings at intake, which remove the stigma associated with mental illness,
- Non-judgmental therapy or a confidential referral to a behavioral health program for every client who felt they needed mental health services,
- Provision of culturally and linguistically competent mental health services (MIDD Implementation and Evaluation Summary Report, year six).

In client surveys, DV survivors receiving MIDD funded services reported improvements in stress-management, decision-making, self-care and enjoyment of life. Clients also praised the insight of MH therapists that helped them work through difficult decisions and to overcome challenges they faced in leaving DV situations. Therapists' knowledge of abuse and trauma were also seen as particularly beneficial (MIDD Implementation and Evaluation Summary Report, year four).

Data collected at the current service provider specializing in services to refugees and immigrants indicated that mental health services were provided in more than 16 different languages (MIDD Implementation and Evaluation Summary Report, year six).

The work of the System Coordinator over the course of MIDD I to date includes:

- Training over 1800 professionals on a variety of topics, including: screening, assessment, clinician safety planning, community resources, working with advocates, engaging with survivors, etc.
- Providing an average of 30 hours of consultation per year with a wide variety of behavioral health, DV, SA, King County administrative, and law enforcement agencies.
- Implementing and supporting many individual program projects, including policy and practice review, referral facilitation, training protocols, and formal relationship-building.

The System Coordinator role has resulted in:

- Increased clinician and advocate knowledge and understanding of the intersections of DV and behavioral health and skills necessary to address them.
- Enhanced agency polices and practice for screening, assessment and response.
- Increased clinician and advocate knowledge of and comfort with effective referral practices.
- Increased access to knowledgeable therapists for survivors with behavioral health concerns
- Increased availability of consultation support for clinicians.
- Improved communication and relationships between behavioral health and DV providers.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

There are two key national sources for best and promising practices in the field of DV. One is "The DV Toolkit: A Toolkit to End Violence Against Women" prepared by the National Advisory Council on Violence Against Women (November 2001). The other is A Review of the Evidence Underlying Domestic Violence Victim Service Programs (Dr. Cris Sullivan, 2007). The community-based services that are deemed best practices or promising practices for an effective DV response system by Dr. Sullivan and/or the DV Toolkit are listed in Table A below.[7]

Table A. Services Identified as Best or Promising Practices

Domestic Violence Services	Best Practice	Promising Practice
Advocacy/support services (including safety planning)	X	
Legal advocacy	X	
Crisis information and referral	X	
Shelters/transitional housing	X	
Culturally specific services	X	
Community education	X	
Support groups		X
Mental health services (esp. DV specific)		X
Children's programs		X

Strategy 13a supports the integration of best and promising practices, including the provision of culturally specific services, offering mental health services within existing community based domestic violence advocacy organizations that are sensitive to the unique needs of DV survivors.

As described above, counseling/mental health services hold promise in helping survivors recover from abuse and successfully move on with their lives. A review of evidence suggests that helpful components include (1) psychoeducation about the causes and consequences of DV; (2) attention to on-going safety concerns; and (3) a focus on women's strengths as well as cultural strengths on which they can draw.[8]

[7] From King County Department of Community and Human Services *2010 Domestic Violence Proviso Response*

[8] Sullivan, C.M., Warshaw, C., & Rivera, E. (2013, October). *Counseling Services for Domestic Violence Survivors,* Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved 12/7/15, from: **www.dvevidenceproject.org.**

All clinicians incorporate cultural competency into their services, and in several cases, staff providing services are bilingual in order to provide the best access to services for non-native English speakers. In addition, this strategy contracts with at least one culturally specific provider with a proven track record for engaging and working with immigrant and refugee populations. The recommended expansion of this strategy would fund additional culturally specific service providers.

In addition, this strategy makes use of an evidence-based screening tool, the Global Assessment of Individual Needs Short Screener (GAIN-SS) with individual survivors upon their admission to services. The GAIN-SS is one of a family of evidence-based instruments used to assist clinicians with diagnosis, placement, and treatment planning. This brief tool allows mental health clinicians to quickly determine which individuals screen positive for mental health or substance use concerns and connect them immediately to treatment services in-house or provide additional assessment to determine whether the need might require referral and connection to more intensive services.

MIDD funded therapists co-located in domestic violence programs utilize evidence-based therapy techniques, such as cognitive-behavioral therapy, Dialectical Behavioral Therapy (DBT), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR), that have been proven to be effective in treating trauma and PTSD.

In December, 2015, King County MHCADSD supported all MIDD funded DV/MH therapists to attend the Common Elements Treatment Approach (CETA) training and learning collaborative provided by Harborview Center for Sexual Assault and Traumatic Stress. CETA is a structured, time-limited component-based cognitive-behavioral therapy (CBT) developed for individuals affected by trauma who have PTSD, anxiety, and/or depression (Murray et al., 2013). Positive clinical outcomes include a 77 percent reduction in mean baseline depression scores, a 76 percent reduction in anxiety, and a 75 percent reduction in posttraumatic stress, among other clinical outcomes (Bolton et al., 2014). Staff will begin using this approach with individuals, as appropriate, in January, 2016.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Although data collection for the current strategy has typically been more focused on outputs (i.e. number screened, number of referrals to treatment, etc.), the survey and anecdotal information outlined in #3 above suggests that this strategy is having impact on the following outcomes as intended:

- Increased access to mental health and substance use treatment services for DV survivors
- The provision of culturally relevant mental health services provided to DV survivors from immigrant and refugee communities in their own language
- Increased resiliency and coping skills among DV survivors served
- Consistent screening for mental health and substance abuse needs among DV agencies
- Improved ability of DV, sexual assault, mental health and substance abuse providers to serve individuals with DV and mental health issues.

Future outcome collection also could focus on the impact of treatment on specific mental health symptoms such as depression, anxiety and post-traumatic stress using standardized measures such as

the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001), the Generalized Anxiety Disorder Screener (GAD-7; Spitzer, et al., 2006), and the Posttraumatic Symptom Scale (PSS; Foa et al., 1999). Some of these measures are currently being piloted at several of the MIDD funded DV/MH sites. Other indicators that DV housing, advocacy and support services document include: increased safety, economic and housing stability, increased access to resources, and connection to on-going community supports. While not accomplished by the MIDD funded therapy on its own, these outcomes are supported by the therapy provided, and in turn support survivors' positive mental health outcomes.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☒ **Black/African-American**
☐ **Children 6-12**	☒ **Hispanic/Latino**
☐ **Teens 13-18**	☒ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☒ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☐ **Veteran/US Military**
☐ **Families**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**

☒ **Other – Please Specify:** Developmentally disabled, hearing impaired

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

Demographic information provided by the current MIDD strategy 13a for the more than 2,000 persons served indicate that:

- 95 percent were female
- 49 percent identified as a person of color (i.e. AFA, API, NA), multiracial or other
- An additional 12 percent identified as Hispanic
- 89 percent were between the ages of 25 and 64
- The number of participants identifying as immigrants or refugees **increased from 37 percent in year one to 59 percent in year 6.**
- Services were provided in **over 16 different languages**

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

Current agency partners provide services to DV survivors in North, East, Central/Downtown Seattle and South County locations. As previously noted, the Central location provides services specifically targeting refugee and immigrant populations.

Although strategy 13a provides MH/SUD services to survivors throughout the County, the system is currently over capacity and would benefit from expansion to include additional staffing at more partner agencies, especially those who serve populations with multiple barriers to access.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

The King County Domestic Violence Survivors Services network already consists of partnerships between King County governmental entities, e.g. the Prosecuting Attorney's Office, Superior Court, District Court, Department of Human and Community Services and others. Outside of KC government, key stakeholders include community-based agencies, law enforcement, housing providers, the City of Seattle and suburban cities, as well as philanthropic agencies (i.e. United Way). These partnerships provide for a range of core services such as legal advocacy, emergency shelter and stable housing, advocacy and support services, safety planning, and programs and supports for the children of DV survivors.

Existing Strategy 13a builds upon the network and current partnerships between the following DV organizations to provide specific, targeted MH and SUD services to survivors:

- Refugee Women's Alliance (REWA)
- New Beginnings
- Domestic Abuse Women's Network
- LifeWire

System coordination activities are provided in partnership with the Coalition Ending Gender-Based Violence (formerly known as The KC Coalition Against Domestic Violence).

Potential partners for the expansion of needed DV specific MH services in King County to populations who experience a higher than average incidence of DV (e.g. homeless, people of color, immigrant/ refugees, people with disabilities, LGBTQ individuals, and survivors in South King County) includes the following organizations:

- Consejo Counseling and Referral Services
- Northwest Network of Bi, Trans, Lesbian and Gay Survivors of Abuse
- Jewish Family Services
- Seattle Indian Health Board
- South King County YWCA

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

Health care reform and Medicaid expansion in Washington State have provided health care coverage for many previously uninsured or underinsured individuals. Mental health treatment is now possible for many who could not access it before, however, as mentioned in multiple areas of this document, community mental health and primary care providers (who typically provide the bulk of publically funded mental health care) are not always in tune to the unique needs of DV survivors or in a position to provide the most culturally responsive services.

The 2015 Human Services Proviso report prepared by the DCHS Community Services Division also indicates other issues that may have an impact on the provision of DV services. These include the following:

- Washington State DSHS has decided not to accept new applications and award allocations to new agencies while a new state-wide DV funding plan is developed. The result is a moratorium for funding new shelter programs at this time.
- United Way adopted a new strategic plan in July 2015 with changes in focus from what previously had been in place. Currently, contracted services for survivors of domestic violence and intervention strategies for DV perpetrators/offenders are scheduled to end at the end of June 2017.

These changes could potentially have a great impact on behavioral health services to DV survivors. With no new funding for shelter resources (although the need for safe housing continues to outpace the resources) and likely changes to currently funded supportive services through United Way, the funding for a comprehensive and holistic system of care for DV survivors may be at risk.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

Existing MIDD strategy 13a has been funded since 2008, so many of the initial barriers regarding implementation and integration of DV/MH systems have been addressed. Some of the barriers that continue to exist include issues related to:

- **Capacity** – therapists are currently funded at 0.8 FTE at only four agencies providing DV specific services to providers; there are routinely waiting lists for MH services at each agency.
- **Funding** – funding for MH therapists does not cover a competitive salary to retain licensed mental health professionals and there is frequent turnover. Therapists are not funded for full-time positions; agencies must hire a "part-time" provider or find additional funding to support a full-time position. In addition, prior to this year, MIDD funded community based programs have not received any inflationary adjustments, so the current level of funding is based on 2008 costs. This contributes to difficulties in hiring and retaining qualified professionals.
- **Isolation of therapists** – although co-locating MH therapists in DV agencies is an advantage, it can also lead to isolation for therapists as they are out there working "by themselves".
- **Philosophical differences** - between DV and MH systems, DV providers have been reluctant to address MH issues and MH providers have not always been sensitive to the unique nature of domestic violence and its impact on survivors' symptoms. In a very real sense, mental health diagnosis and treatment can inadvertently place women in jeopardy and increase their abusers' control over their lives.

The issues described above and potential impacts/strategies to address will be included in the unintended consequences sections below.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Consequences of implementing behavioral health services for DV survivors represent both benefits and challenges. Some of the benefits include:

- **Positive culture shift** - DV organizations have become more integrated and collaborative. Mental health consultation and education are provided for DV advocates, and advocates cross-train MH staff around DV issues. As a result there is increased collaboration, as well as increased capacity in both MH and DV agencies to provide effective services to survivors with mental health concerns.
- **Consistent screening** – Agency-wide screening for mental health and chemical dependency is now occurring in MIDD funded DV agencies. This has begun to normalize concerns survivors may have and reduce the stigma often associated with these issues. In addition, this helps advocates understand and feel less anxious when faced with MH or SUD issues and more confident in their response. Consequently, survivors are better supported in connecting to needed services more quickly and seamlessly.
- **Common understanding/better access** – DV advocates now recognize that survivors with MH issues can be adequately served within a DV organization, rather than feeling that it is too risky to work with them and/or that they belong to a different system and promptly referring out. Consequently, survivors with MH concerns have increased access to a more comprehensive array of services in an environment where they feel a greater sense of belonging.
- **Community connections** – This strategy has led to increased collaboration and improved relationships with community mental health providers. This allows for better facilitation of appropriate referrals in crisis situations and for ongoing community-based care for survivors who need more intensive services and supports.

Some of the challenges of this model include:

- **Time is too short** – due to capacity issues, MH sessions are often limited to 10 or less. While clients benefit from the intervention, limiting the time can be counterproductive and not in alignment with the principles of trauma-informed care or domestic violence advocacy. When attempts are made to transition clients to outpatient treatment, many are reluctant to switch programs/therapists and some drop out of services as a result. A client-centered approach, especially with regard to time spent in treatment, will likely glean better outcomes.
- **Capacity** – also noted as a barrier above. Therapist caseloads are typically always full with a waitlist. Programs have tried to address this issue by incorporating interns into the program and by offering more groups.
- **Outcome/data collection challenges** - For many MIDD clients, the abuse has not ended and the negative mental health effects of the DV are ongoing. Events outside of the therapists' influence can have significant impact on outcomes. Administering outcome measures can be difficult when survivors are in hiding, at a shelter and/or in crisis.

- **Isolation of therapists** – also noted as a barrier above. Agencies have addressed this by organizing regular consult meetings where agency MH clinicians get together for support and case staffing.

4. What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?

Not funding MHPs at DV agencies would impact the system in multiple ways, including:

- Survivors would lose access to specialized, trauma-informed/focused, holistic services.
- Survivors would lose access to culturally and linguistically appropriate DV/SA services.
- Programs would have to go back to square one referring survivors out to external programs
  - Prior to the MIDD, survivors would have to access multiple agencies to receive both DV and MH services, tell their stories multiple times, etc. MIDD funded MH staff/services significantly reduced the barriers and survivor stress required to receive holistic support.
- Loss of culturally specific services for refugees. Refugees typically experience additional layers of trauma in addition to DV/SA. Advocates need skills and support afforded by the MIDD to address the complex layers of DV and MH specific to refugee survivors.
- The DV continuum of care would lose significant ground:
  - Collaborative systems and relationships that have taken time to build would be lost.
  - Loss of credibility – systems have begun to work together to encourage survivors to come forward and get help and MH treatment. This trust would be lost without the unique services and holistic response to back it up.
- Cost efficiencies would be eliminated – the per-client cost compared to other strategies is relatively low, as well as more aligned with survivors' needs and easier to access than traditional MH treatment.
- Survivors without other means to pay for MH support would have significantly fewer/no options for MH services appropriate for DV.
- Agency culture, skills, training and access to resources and consultation would be significantly reduced or eliminated. Currently, the therapists provide training and consultation for agency staff, volunteers, and other community providers.
- Interns would lose a rare opportunity to be housed in DV program/work with DV survivors.

The MIDD-funded Systems Coordinator is the only position with a systems-level focus on the fields of CD, DV, MH and SA in King County. Some of the impacts of not funding Systems Coordination would include:

- Behavioral Health agencies would lose:
  - Free, tailored training opportunities on a wide range of topics directly relevant to delivering appropriate care for DV and SA survivors.
  - Tailored, agency-specific recommendations for DV-related policies and practices, including screening, assessment, survivor-engagement strategies, safety planning, working with DV agencies, and community referrals.
  - Assistance with and facilitation of relationship building with DV and SA agencies.
  - Assistance with and facilitation of reciprocal consultation between DV and SA agencies.
  - Consultation on individual cases, community resources, and follow-up referrals.

- A DV and SA voice at County-wide leadership bodies, such as the King County Mental Health Advisory Board.

- DV/SA agencies would lose, all of the above, in addition to:
  - Communication and coordination on mutual goals and efforts between all programs in Strategies 13a, 13b and 14a, including enhanced outcome collection.

- DV survivors would lose:
  - Integrated and coordinated care from providers with specialized knowledge and skills sets unique to addressing the needs of DV survivors.

5. What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

Mental health services are available through the Regional Support Network of outpatient providers to those who meet the eligibility criteria for access to care and who have Medicaid or other alternative funding (i.e. private insurance). Mental health services are also often available through primary care centers for those who have health insurance. While these resources can provide some level of MH support to DV survivors, they are often not ideal for a number of reasons:

- Many survivors, despite healthcare expansion, still do not have access to healthcare (i.e. for many undocumented immigrants, working poor who can't afford costly premiums, etc.)
- Services in community MH agencies are not always tailored and/or culturally specific for refugee and immigrant populations and other "non-white" or "non-mainstream" groups.
- MH staff at non-DV agencies often do not understand DV survivors' needs, do not always provide a trauma-informed approach, or understand the safety concerns and potential negative impacts of accessing MH services for DV survivors.
- DV survivors are often heavily involved in legal proceedings related to their situation. Community MH providers are often unable to help survivors navigate difficult, complex legal systems.
- Most community MH providers are not formally connected to the DV advocacy system and do not offer the full range of services and supports available within the DV network.

Although cost per person analysis has not been conducted specifically for strategy 13a, estimated costs are on average approximately $600 per person.

E. Countywide Policies and Priorities

1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

The work of existing MIDD strategy 13a aligns closely with the goals, objectives and planned outcomes for a number of King County initiatives including the following:

- **Accountable Communities of Health** – System coordination goals in both the Domestic Violence (13a) and Sexual Assault (14a) MIDD service strategies are aligned with this initiative's outcomes to improve access and coordinate service delivery and collaborative decision-making across multiple sectors and systems, as well as developing a set of shared priorities and strategies for holistically addressing the needs of domestic violence survivors.

- **All Home, formerly the Committee to End Homelessness** – although this MIDD strategy does not directly provide housing for DV survivors (who are at higher risk for homelessness), it does support the goal of addressing crises as quickly as possible, assessing needs and connecting people to supportive services to address identified needs, achieve stability and prevent further escalation of the crisis.

- **Health and Human Services Transformation Plan** – the provision of MH and SUD services to DV survivors is directly related to the Health and Human Services Transformation Plan's vision of increasing community health and well-being by "focusing on prevention, embracing recovery and eliminating disparities." As previously discussed, provision of trauma-informed, culturally responsive, behavioral health services to abuse survivors on-site at DV programs supports this initiative's planned outcome of "improving access to person-centered, integrated and culturally competent services when, where and how people need them."

- **King County Strategy Plan (2010)** – the KCSP prioritizes the "need to provide safe communities and accessible justice systems for all." MIDD strategy 13a exemplifies this goal by offering DV survivors psychosocial resources to help end the cycle of violence. In addition, the systems coordination portion of this strategy strengthens linkages and collaborations within cities and communities aimed at improving partnerships within the DV response system.

Strategy 13a, especially the proposed program expansion, aligns with the King County **Equity and Social Justice Initiative** (see #3 below for specifics), by focusing increased funding on services for survivors from marginalized communities.

2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?

MIDD strategy 13a provides behavioral health services in accordance with the 2012 King County Recovery and Resiliency Ordinance that promotes service delivery within a "trauma-informed, recovery and resiliency focused system that offers respect, information, connection and hope."

When seeking mental health services through the DV/MH programs supported by this strategy, survivors are generally viewed as experiencing psychiatric symptoms that are "understandable responses to terror and entrapment that are likely to resolve with safety and support" rather than long-term pathology or specific deficits within the victim. Assessment begins with a "what happened to you" vs. "what is wrong with you" approach.

MH staff at each of the partner agencies receive specific training in "trauma informed care" and as previously described, most specialize in using trauma focused approaches such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Therapy (DBT), Cognitive Processing Therapy (CPT), Prolonged Exposure (PE) Therapy, etc. Treatment for individual survivors is based on individual need and/or preferences and provides a mix of psychoeducation, individual and/or group treatment.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

King County's Fair and Just Ordinance 16948 (2010) requires that organizations intentionally consider equity and integrate it into decisions and policies, practices, and methods for engaging all communities. The County is committed to serving all residents, regardless of race, culture or disability, by promoting fairness and opportunity, eliminating inequities and working to remove barriers that limit an individuals' or a community's ability to fulfill their full potential.

MIDD strategy 13a aligns closely with this mission as it is designed to improve access to behavioral health treatment for DV survivors by eliminating some of the barriers that exist in the current behavioral health system. Clients can access treatment at the same agency where they are receiving other advocacy and supportive services and do not need to meet access to care (diagnostic/functional) requirements or be eligible for Medicaid funding to receive services.

Strategy 13a also targets identified populations with multiple barriers to access and a high need for services to address domestic violence and other significant trauma history, i.e. persons of color, refugee/immigrant, persons with disabilities, etc. and prioritizes services to survivors in their own language. Emphasis is also placed on cultural responsiveness in addressing the unique perspectives and impact of DV within different populations. The proposed expansion would fund additional agencies that provide services within and specifically tailored for marginalized and underserved communities.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

Resources needed to implement this strategy include:

- Staff (salaries and benefits)
- Supervision
- Administrative and operating costs
- Space and equipment (cell phone, computer, etc.)
- Training

2. **Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.**

Funding for the existing strategy was developed at 2007-08 rates and is currently approximately $310,000 per year. This funds four 0.8 FTE MH Clinicians and a portion of the 0.8 FTE System Coordinator (partial funding for this position is provided by strategy 14a).

Agencies currently funded under this MIDD program have spent seven years building capacity to provide specialized behavioral health services specifically tailored for survivors of domestic violence. Most have used core MIDD funding to leverage additional resources, such as therapy interns, to expand service capacity beyond what MIDD funds can support. What is needed to more fully meet the demand at these agencies is to be restored to full funding for 1.0 FTE per organization.

To support the existing strategy and originally planned service levels, costs for a 1.0 FTE therapist (per organization and 1.0 FTE system coordinator) with benefits, supervision, office, phone, admin and other operating costs would be approximately $100,000 per FTE ($55,000 - $60,000 Salary, 25% benefits, 25% supervision, operations, admin) for **a total system cost of approximately $500,000.**

Expansion to include up to five additional behavioral health clinicians co-located at five additional agencies located throughout King County would cost **an additional $500,000.**

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

Medicaid behavioral health funding is accessible for **some participants** to receive care through an outpatient benefit within the current mental health provider network; however, as already addressed, many individuals do not have access to this funding and services provided are not always the best "fit" for DV survivors.

Grant funding might be available to support services being currently provided within strategy 13a and is currently being utilized at some agencies to subsidize additional costs; however, this source of revenue is not consistent and/or comprehensive and dependence on it could lead to further system fragmentation. There is no other source of dedicated funding to support these unique, specialized services in King County.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?**

As this is an existing strategy, additional implementation factors don't really apply. However, in looking at factors for implementation of expanded sites, this would involve factors such as identifying agencies committed to providing an integrated model for MH/SUD services coming on board and assessing how quickly they are able to on-board staff, receive training and orientation from the system coordinator, develop policy and procedure, etc. It also might be helpful for the existing network to do a review of what has worked or not worked regarding implementation to promote best practices going forward.

    b. **What are the steps needed for implementation?**

Organizations already providing services within strategy 13a would not need additional implementation time (other than increasing positions from 0.8 FTE to full-time). New entities joining the partnership may need a brief start-up period to hire new staff, develop a plan to integrate DV specific mental health services into their agencies, and to determine what adaptations are necessary to ensure the service design is culturally-appropriate for the communities they serve. Implementation of expanded services could likely occur within three to six months.

    c. **Does this need an RFP?**

No, rather than an RFP, it would be more efficient and cost effective to continue to utilize existing organizations that have piloted this project and continue to develop the integrated model of DV/behavioral health services within community-based DV advocacy organizations. Expansion efforts should be focused to include organizations that have the capacity to provide DV core services (as defined by the DV network and key stakeholders) that include: legal, housing, medical, social service and community advocacy, safety planning assistance, crisis intervention and support, information and referral, advocacy-based counseling and parenting support, professional training, community education and outreach. Agencies should also evidence a commitment to partnership within the network to provide mental health services to DV survivors within an integrated, trauma-informed framework.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

Strategy Title: Mental Health Services for Domestic Violence Survivors with Associated Coordination and Training

Strategy No: #13a Domestic Violence/Mental Health Services and System Coordination

Policy Goal Addressed:

- A reduction in the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

Individuals who experience ongoing abuse by an intimate partner ("survivors") are at increased risk for developing depression, post-traumatic stress disorder (PTSD), and other mental health problems. Analysis of research studies across multiple settings serving battered women, including hospital emergency rooms, and psychiatric settings, indicated that an average of 48% of women were experiencing depression and 64% were experiencing PTSD[9].

There are many access barriers to survivors of domestic violence (DV) who have mental health and substance abuse concerns. DV survivors experience unique safety concerns due to stalking, threats, physical violence, and ongoing emotional abuse by their abusive partners. Nationally and in King County, providers of mental health and substance abuse treatment services are often unfamiliar with the needs of DV survivors. Many providers of DV services are unfamiliar with screening for or responding to mental health and substance abuse issues. As a result of these and

[9] *Domestic Violence, Mental Health and Trauma, Carole Warshaw and Holly Barnes, Domestic Violence and Mental Health Policy Initiative, April, 2003.*

other barriers, DV survivors who need mental health services are often either not identified or are unable to receive services.

Community-based DV advocacy programs in King County currently provide a broad range of services to DV survivors, including safety planning, support, shelter and transitional housing, assistance with employment, etc. at confidential locations. These programs do not currently have the ability to assess for or respond to survivors' mental health concerns. Nationally and in King County, providers of mental health and substance abuse treatment services often do not have the ability to assess for or respond to the unique safety and support needs of DV survivors.

◊ *B. Reason for Inclusion of the Strategy*

Services described in this strategy will increase access to early intervention for mental health and substance abuse issues, and prevention of severe mental health and substance abuse issues for survivors of DV, throughout King County.

As described above, many DV survivors who are experiencing or are at-risk for significant mental health and substance abuse problems can not access services. This can have a negative impact on their functioning, their safety, and their ability to leave abusive relationships. DV survivors from East African, Eastern European, South Asian and other immigrant and refugee communities, face the additional barrier of the lack of available culturally-appropriate mental health services.

The 2006 Safe and Bright Futures report and 2006 WA State Coalition Against Domestic Violence Fatality Review Project report recommend that mental health and substance abuse professionals and domestic violence programs: a) collaborate on cross-training in order to increase their ability to provide the appropriate range of services to domestic violence survivors who are suicidal or have other mental health concerns, and b) coordinate services and ensure systematic changes to agency policies, procedures and practices.

◊ *C. Service Components/Design*

Licensed mental health professionals (MHPs) with expertise in DV and substance abuse will be employed by community-based domestic violence victim advocacy programs around King County to provide assessment and mental health treatment to DV survivors. Treatment will include brief therapy, and mental health support, in group and/or individual sessions. MHPs will provide assessment and referrals to community mental health and substance abuse agencies for those DV survivors who need more intensive services. One of these MHPs will be housed at an agency serving immigrant and refugee survivors of DV. Mental health professionals will offer consultation to DV advocacy staff and staff of community mental health or substance abuse agencies. In addition, a Systems Coordinator/Trainer will be funded to coordinate ongoing cross training, policy development, and consultation on DV and related issues between mental health, substance abuse, sexual assault and DV agencies throughout King County.

◊ *D. Target Population*

- DV survivors who are experiencing mental health and substance abuse concerns will have access to early intervention services and prevention of severe mental health and substance abuse issues.
- Providers at sexual assault, mental health, substance abuse, and domestic violence agencies who work survivors of DV with mental health and substance abuse/substance abuse issues and participate in the coordination and cross training work of this program.

◊ *E. Program Goal*

Integrate mental health services within community-based domestic violence agencies, making them accessible to DV survivors. Improve screening, referral, coordination and collaboration between mental health, substance abuse, domestic violence and sexual assault service providers.

◊ *F. Outputs/**Proposed** Outcomes*

Total number of clients served per year: 175-200
Total numbers of counselors and advocates trained per year: 200

Expected outcomes for Domestic Violence survivors served

- Increased access to mental health and substance abuse treatment services for domestic violence survivors
- Culturally relevant mental health services provided to DV survivors from immigrant and refugee communities in their own language
- Decreased mental health concerns among DV survivors served
- Increased resiliency and coping skills among DV survivors served

Expected System Outcomes

- Consistent screening for DV among participating mental health and substance abuse agencies, and increased referrals to DV providers
- Consistent screening for mental health and substance abuse needs among DV agencies
- Improved ability of DV, sexual assault, mental health and substance abuse providers to serve individuals with DV and mental health issues

2. Funding Resources Needed and Spending Plan

Dates	Activity	Funding
October-December, 2008	Funding for start-up, equipment, administrative costs	$31,000
January-December 2009	Funding for 3.5 MHPs and a.5 FTE systems coordinator/trainer, as well as interpreter services, to provide services and service coordination. (Funding includes	$310,000

	administrative costs) Training is provided to DV, substance abuse, and mental health providers on screening protocols. Coordination efforts are put in place.	
2009	Total Funds	**$310,000**
Ongoing Annual	Total Funds	**$310,000**

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and Type of Providers (and where possible FTE capacity added via this strategy)*

Providers will provide regional access to services: Domestic Abuse Women's Network in South King County, Eastside Domestic Violence Program on the Eastside, and New Beginnings for Battered Women and their children in Seattle. The DV program at Refugee Women's Alliance (REWA), which serves 16 language communities, will house a mental health provider to serve refugee and immigrant survivors. The King County Coalition Against Domestic Violence will house the .5 FTE systems coordinator/trainer, as this community-based coalition has unique leadership with and access to all of the community-based DV agencies, as well with Community Sexual Assault Providers described in #14a in King County.

3 MHPs added to community-based DV agencies

.5 FTE MHP housed at culturally-specific provider of domestic violence and sexual assault advocacy services (linking with the .5 FTE in the Sexual Assault Services strategy 14a)

.5 Systems Coordinator/Trainer (linking with the .5 FTE in the Sexual Assault services strategy 14a).

Interpreters for service provision to immigrant and refugee survivors at REWA

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

Dates:	Activity:
October-December 2008	Start up (hire and train MHPs at DV agencies and hire systems coordinator)
January 2009	Staff at DV agencies work with staff at mental health agencies to develop protocols for service provision at DV agencies
February-March 2009	Protocol development and staff training continue.
March 2009	Services begin.
May-December 2009	Services continue Training is provided to DV, sexual assault, substance abuse, and mental health providers on screening

Dates:	Activity:
	protocols, coordination efforts in place

◊ *C. Partnership/Linkages*

This strategy will involve a partnership between community based DV agencies, mental health and substance abuse treatment programs, and sexual assault agencies. Mental health professionals will consult with and refer to staff of the Domestic Violence Early Intervention/Prevention program described in strategy 13b. In addition, there will be linkages with the DV and Mental Health Collaboration funded by the Office on Violence Against Women through the City of Seattle.

Note: This strategy is linked with the sexual assault strategy, which will fund also fund an .5 FTE systems coordinator and trainer to providing systems coordination and training on sexual assault issues, and an .5 FTE MHP to serve immigrant and

refugee victims of sexual assault who are experiencing mental health and substance abuse concerns.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Staff identified and hired by January 31, 2009

Services to DV survivors begin March, 2009.

Systems coordination and training efforts begin March 2009.

◊ *B. Procurement of Providers*

The strategy is designed to be implemented within the DV provider community by agencies providing a full continuum of services, including emergency shelter, transitional housing and community-based advocacy programs. The County will contract with the three large regional providers of this service continuum, as well as with the Refugee Women's Alliance, which is uniquely positioned to serve survivors from refugee and immigrant communities. DV agencies offer services in confidential locations, and have a high level of statutory protection for client records and client communication (Relevant statutes are RCW 5.60.060 (8), 70.123.075, 70.123.076).

◊ *C. Contracting of Services:*

See above.

◊ *D. Services Start date(s)*

March 2009.