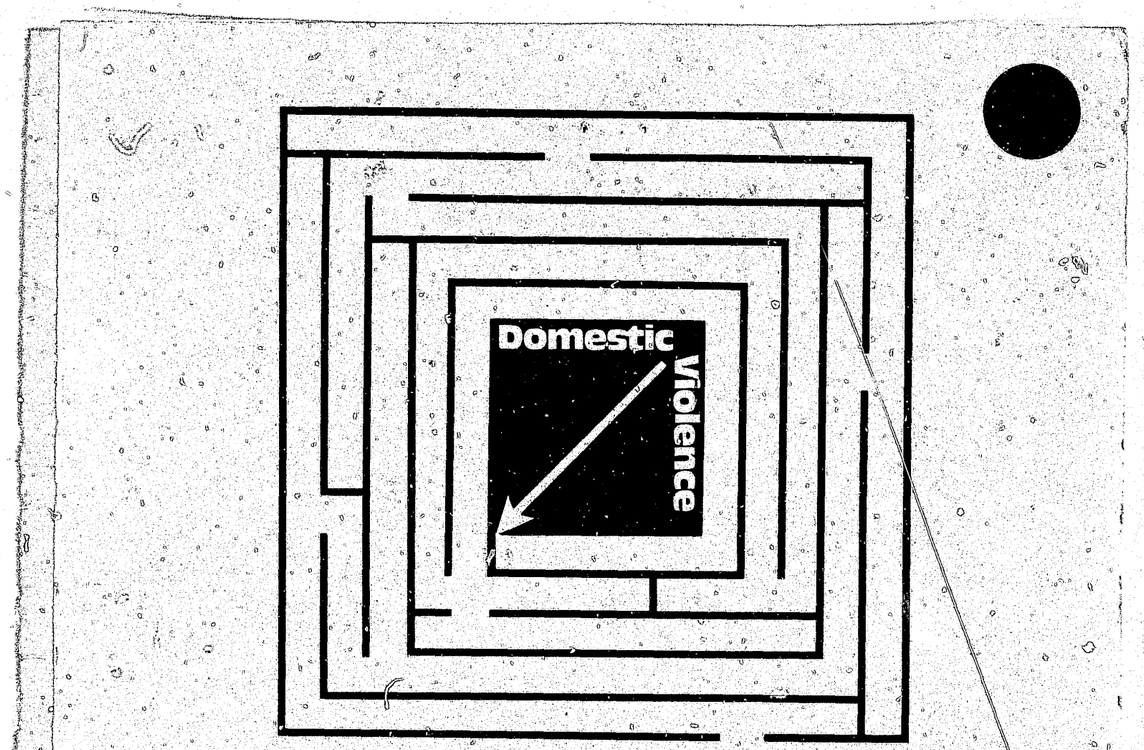

Domestic Violence

FINAL REPORT: VOLUME I

SERVICES TO VICTIMS OF DOMESTIC VIOLENCE: A REVIEW OF SELECTED DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAMS Vol. I

Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Washington, D.C. 20201

FINAL REPORT: VOLUME I

SERVICES TO VICTIMS OF DOMESTIC VIOLENCE: A REVIEW OF SELECTED DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF PROGRAM SYSTEMS

OCTOBER 1981

200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C. 20201

This report was developed by CSR, INCORPORATED, under a contract from the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (HHS-100-79-0815), and is part of a three volume report on the delivery of services to victims of domestic violence. However, the results and opinions expressed in this report do not necessarily reflect the position or policy of the Department.

FOREWORD

This study was undertaken in September 1979 when legislation for a categorical program of financial assistance for the provision of services to victims of domestic violence was being considered by the Congress. The Department of Health and Human Services, recognizing that violence within the home was a serious problem, wanted to know how existing programs, financed by the Department, responded to the needs of domestic violence victims and their abusers. Because none of the programs of this Department had a specific mandate to provide services to these victims, no information on service availability and usage was routinely collected.

The study indicates that some DHHS programs have been utilized within the flexibility of their legislative authorization to respond to these needs. At both the State and community levels staff have developed special programs, outreach efforts, and coordinating and referral mechanisms. Most respondents to the survey, however, did not believe that sufficient resources were available in their State or community to meet the need. The three-volume final report presents the findings of the study from different perspectives: Volume I reports the findings on a program-by-program basis; Volume II presents case studies on how services are delivered in three communities; Volume III presents, on a State-by-State basis, the findings from the interviews conducted with State level staff.

With the enactment of the Omnibus Budget Reconciliation Act in August of 1981, some of the categorical DHHS programs discussed in this report are now consolidated into State block grant programs. Specifically these are:

- Title XX--now a block grant which provides States with more flexibility in providing a wide range of social services including emergency shelter for children and adults, counseling for the entire household unit, including the abuser, and employment referral and training.

- Community mental health centers, alcohol formula grants and alcoholism treatment and rehabilitation, and drug abuse demonstration and community services programs--these programs have been consolidated into a single, State grant for mental health, alcoholism and drug abuse services.

- Community health centers--although direct Federal funding will continue for fiscal year 1982, this program will be a block grant operated by the States beginning October 1982.

Additionally, the child abuse and neglect prevention and treatment project grant demonstration program has been included in a broad-based social services discretionary fund which is managed by the Assistant Secretary for Human Development Services.

Because of these and other legislative changes affecting the programs included in this study, the information presented in this report may no longer reflect statutory and regulatory requirements and prohibitions which are effective as of October 1, 1981. However, the report does provide a state-of-the-art perspective on how some DHHS programs have and can be used to provide assistance to victims of domestic violence.

Gerald H. Britten
Deputy Assistant Secretary
for Program Systems

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In addition, we extend our appreciation to the many program staff at the Federal, State and community levels, to members of the National and State Coalitions Against Domestic Violence, and to all other individuals who provided comprehensive and thoughtful information for this study. Finally, our interviewers for the Community Survey deserve accolades for the conscientious and able manner in which they performed their work.

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EXECUTIVE SUMMARY

This study, initiated by the Department of Health and Human Services (DHHS) in October, 1979, provides information on where and how selected DHHS, State, and locally funded programs are making services available to victims of domestic violence. The study's Final Report entitled, "Services to Victims of Domestic Violence: A Review of Selected Department of Health and Human Services Programs," was prepared under Contract HHS-100-79-0185 by CSR, Incorporated, whose main office is located at 805 15th Street, N.W., Washington, D.C., 20005.

BACKGROUND

Public concern about violence in the family has increased over the past several years. This concern was directed first on helping abused children. Recently, there has been growing concern about providing help to abused spouses and their families.

The service needs of battered women extend to nearly every aspect of their personal and family life--physical and mental health, economic security, legal protection, interpersonal relationships, and general well-being. The existing human services delivery system, comprised in large part of DHHS funded programs, has the potential to help meet the comprehensive service needs of victims of domestic violence and their families. However, the extent to which DHHS funded programs currently do meet the needs of battered women and their families was not investigated prior to this study.

OBJECTIVES OF THE STUDY

The following DHHS programs were included in the study: Aid to Families with Dependent Children (Social Security Act, Title IVA); Emergency Assistance (Social Security Act, Title IVA); Child Welfare Services (Social Security Act, Title IVB); Medical Assistance (Social Security Act, Title XIX); Social Services (Social Security Act, Title XX); Child Abuse and Neglect Prevention and Treatment (Child Abuse Prevention and Treatment Act); Community Health Centers (Public Health Services Act, Title III, Section 330, as amended); Community Mental Health Centers (Community Mental Health Centers Act of 1975, Title III, Public Health Services Act, as amended); Indian Health Services (Indian Self-Determination Educational Assistance Act); Work Incentive Program (Social Security Act, Amendments of 1967); Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970); and Drug Abuse Demonstration and Community Service Programs (Drug Abuse Office and Treatment Act of 1972, as amended).

In addition to the DHHS funded programs, State and local programs on domestic violence and local shelters for battered women were included in the study sample. Further, when "close and substantive working relationships"

related to the problem of domestic violence were identified between the surveyed DHHS funded programs and other Federal or private programs, these other programs were surveyed as well.

STUDY OBJECTIVES AND METHODOLOGY

Three primary objectives were developed for this study -- first, to assess the extent to which staff from the selected programs provide assistance to battered women and their families; second, to identify legal and/or administrative constraints of programs which affect the extent to which staff serve this population; third, to identify other factors which have an effect on service provision, for example, staff opinions and community characteristics.

Two distinct surveys were conducted to obtain the data required to address these objectives: a State level survey and a community level survey.

The State survey, conducted by telephone, was initiated in March, 1980. Every State and the District of Columbia were included in this phase of the study. Respondents were selected on the basis of their knowledge of the selected program's policies, procedures, regulations, and services, and/or their knowledge of the selected program's activities related to the problem of domestic violence. The findings reflect a composite viewpoint of each program's activities. Administrators from a total of 484 programs were interviewed; the response rate for the State survey was 98 percent.

The field work for the community survey was initiated in July, 1980. Fifteen States were initially selected based on stratification of all States according to geography and level of service activity for victims of domestic violence as reflected by the State survey data. From these 15 States, 88 communities were selected, based on a random probability sampling approach.

A matrix of all programs under study located in each of the 88 communities was prepared. Specific programs in each community then were selected randomly for inclusion in the survey. The number of DHHS funded programs sampled across all 88 communities ranged from 25 to 47, except for the Indian Health Services and Child Abuse Prevention and Treatment programs which had four and six local programs, respectively. A total of 444 programs, with interviews from 1,313 respondents, constitute the computerized data base for the community survey. The distribution of the 1,313 respondents, according to job function, is: 368 administrators, 724 direct service staff, and 221 staff who function in both capacities.

Eight additional sites (two Indian reservations and five communities in California) were selected for special analyses. Interviews with administrators and direct service staff from another 45 community based programs form the basis for these analyses. The findings from these interviews are treated separately in a supplemental case study report and in Chapter 2 of the Final Report.

MAJOR FINDINGS

The major study findings relate to the scope of current DHHS program efforts; the potential of DHHS programs to serve battered women and their families; and State and local domestic violence program initiatives. These findings are summarized in the following sections with particular emphasis on the current efforts and potential of the DHHS funded programs.

Domestic Violence Victims as a Focus of DHHS Program Efforts

Each DHHS funded program surveyed is authorized to provide financial assistance/services to individuals or families who meet the program's eligibility criteria. The eligibility criteria vary from program to program, but, in general, the selected programs concentrate on helping persons who have incomes under specified levels and/or who have specified service needs.

Although the legislative mandates for the DHHS programs surveyed do not reference victims of spouse abuse as a target population, some victims are eligible to receive program services. These victims possess other characteristics which concur with the program's mandate and eligibility criteria. Of special interest to this study is the extent to which State and local staff, on their own initiative or in response to State or community concern, have singled out victims as a focus of program efforts.

At the State level an emphasis on battered women varies considerably across the DHHS funded programs surveyed. None of the Work Incentive Program (WIN) respondents reported a focus on battered women, while respondents from 34 percent of the Social Services programs reported this focus. This varied emphasis on battered women is found at the community level as well. None of the WIN or Medicaid programs surveyed at the local level have a focus on battered women, while 29 percent of the Community Mental Health Centers do. With the exception of several respondents from the Child Welfare Services program reporting a focus on the children of battered women, children, abusers, and battered men are less likely than battered women to be a focus of any DHHS funded program efforts.

Where DHHS funded programs have a focus on battered women, a larger proportion of State level respondents than community respondents report this focus. (The two exceptions to this trend are Emergency Assistance and Community Mental Health Center programs.) Divergence between State and local program respondents' reports is particularly evident in five of the DHHS funded programs surveyed: the Child Welfare Services, Child Protective Services, Social Services, Alcoholism Treatment and Rehabilitation/Alcohol Formula Grants, and Drug Abuse Demonstration/Community Service programs. It may be that while activities to help battered women are planned or discussed by staff of these programs at the State level, the realities of funding and staff limitations lead staff at the community level to report only on activities which are implemented.

In brief, these findings show that few staff of DHHS funded programs are focusing on battered women as a special subpopulation, particularly staff

involved in direct intervention at the local level. The children of battered women, battered men, and abusing spouses are the focus of program efforts even less often. However, the few State and local DHHS funded programs with a focus on victims and their families demonstrate that States and communities have flexibility in determining program emphases within the broad legislative mandates of these DHHS programs.

Defining the Problem of Domestic Violence

This study also investigated the extent to which staff of DHHS funded programs, at State and local levels, have established/adopted a definition of domestic violence. The existence of a definition indicates formal recognition of the problem.

Very few DHHS funded programs have established or adopted definitions of domestic violence. At the State level, Social Services (22%) and Alcoholism Treatment programs (18%) are more likely than other DHHS funded programs to have such definitions. At the community level, the Emergency Assistance (23%), Child Protective Services (16%), and Social Services (16%) programs are more likely to have established a definition. Most frequently, respondents from the programs with a definition of domestic violence indicated that the definition originated in State domestic violence legislation.

In brief, these findings show that most DHHS funded program staff are operating without a program definition of domestic violence. This factor may be curtailing staff recognition of domestic violence as a problem experienced by their service population. On the other hand, the establishment of a very specific program definition of domestic violence was cited by some respondents as restricting staff from responding to the needs of victims seeking services.

Establishing Program Goals

Across the programs surveyed, there is considerable flexibility granted by DHHS to States and communities in the determination of program goals, as long as the goals have relevance to the broader legislated mandate. Thus, one purpose of this study was to assess the extent to which DHHS funded programs, at State and local levels, have goals pertaining to the needs of abused spouses and their families.

Again, the findings show that some State and local staff are taking advantage of the flexibility provided within their respective program mandates. At the State level, this is especially true of staff from the Social Services (20%), Alcoholism Treatment (26%) and Drug Abuse programs. At the local level, Community Mental Health Center staff (32%) have exercised this option most often.

Of note are the differences across DHHS funded programs regarding the extent to which State and community programs have developed goals to assist battered women. In some programs (e.g., Child Protective Services and Alcoholism Treatment) a larger percentage of State than community respondents identified such goals. Perhaps some State plans include these goals, but

the goals are not adopted consistently by all community service providers. In contrast, in other programs surveyed (e.g., Medicaid and Community Mental Health Centers), a larger percentage of local than State level respondents identified goals for battered women. Some local staff apparently are establishing these goals in response to the problem of spouse abuse evidenced in their community.

Although a minority of DHHS funded programs surveyed have goals pertaining to the needs of battered women, there appears to be the potential for further development in this area.

Providing Services and Coordinating Resources

All DHHS funded programs offer services which battered women and their families may receive on the basis of their broader eligibility for program assistance. There were no data available from respondents which would show the number of these victims currently receiving various program services.

Across all DHHS funded programs surveyed, a minority of States and/or communities have elected to provide some special services for battered women. At the State level, those programs most frequently reporting special services include Social Services (38%), Community Mental Health Centers (27%), Drug Abuse (22%), Alcoholism Treatment (20%), and Child Protective Services (20%). At the community level, it is the Community Mental Health Centers (43%), Social Services (25%), and Drug Abuse Treatment (24%) programs which are more inclined to have special services.

A broad range of activities was reported by respondents from DHHS funded programs offering special services to victims and their families. Examples include the provision of food, clothing, and temporary shelter; offering supportive services such as counseling and client advocacy; assigning specialized staff to work with battered women identified by other program staff; training staff to serve as paralegals for battered women involved in court processes; operating 24 hour hotlines; and establishing special family counseling and peer group counseling services for victims.

Although these examples suggest that some DHHS program resources can be directed toward victims of spouse abuse, the vast majority of respondents indicated that their programs have few, if any, resources which could be used especially for victims and their families. However, many respondents reported that program staff are attempting to assist victims through coordination efforts with other agencies. Thus, it is not surprising that many respondents also believe that State and local coordination of services is the most feasible future program activity.

Coordination Strategies

DHHS funded program staff have used several mechanisms to coordinate activities with other agencies; for example, participation on State/local domestic violence task forces, Governor's Advisory Councils and Commissions on Women; service agreements with other programs/agencies; informal meetings with other program staff to discuss service provision to victims and their

families; and sharing of staff on jointly sponsored activities related to the problem of domestic violence.

Respondents identified some specific accomplishments resulting from these coordination activities: 1) clarification of DHHS financial reimbursement policies for services provided by shelters to battered women; 2) establishment of formalized referral procedures between and among programs; 3) increases in the numbers of battered women referred by programs to various needed services; 4) the development of DHHS and shelter record keeping procedures to ensure client confidentiality; 5) joint staff training on domestic violence issues; 6) publication of a resource handbook for victims of domestic violence; 7) collection of needs assessment and incidence data; and 8) community education campaigns.

The coordination activities assumed by the program staff in some States and communities include a wide spectrum of human service programs (e.g., the Departments of Social Services, Education, Criminal Justice, Transportation, Public Health, and Coalitions Against Domestic Violence). On the community level, however, coordination is more likely to involve a small number of program staff who operate on a case-by-case basis.

Advocacy and Staff Training

This study also examined the extent to which DHHS funded programs are involved in advocacy and staff training related to the problem of domestic violence. Respondents were asked to report any advocacy activities on behalf of victims occurring within and/or outside their program and any staff training related to the problem.

Across all DHHS funded programs surveyed, some program staff identified themselves or co-workers as advocates for domestic violence victims. These advocates are more likely to work within the Alcoholism Treatment, Drug Abuse, Social Services, Child Protective Services, and Child Welfare Services programs. DHHS program staff are engaged in several kinds of advocacy activities: 1) flexibility in interpreting program regulations to facilitate services to battered women; 2) involvement in community education campaigns; 3) support of the establishment of shelter programs; 4) inclusion of services for battered women in program plans and budgets; 5) lobbying for State domestic violence legislation; and 6) sharing knowledge with battered women about services available in the community. The staff interviewed for the Indian Health Services program also see themselves as advocates for battered women. Their efforts focus on encouraging Native American battered women to advocate more for themselves and on encouraging tribal governments to recognize domestic violence as a serious problem on the reservation.

Respondents from DHHS funded programs also were asked to report any training they or their co-workers had received to better understand the problem of domestic violence. Across all DHHS funded programs surveyed, some staff have received this training. With the exception of the Child Welfare Services and Child Protective Services programs, this is a more common occurrence for program staff at the community level than at the State level. On the local level, a large percentage of the Community Mental

Health Centers (71%), Drug Abuse (48%), Alcoholism Treatment (45%), Social Services (44%), and Child Protective Services (42%) programs have staff who received some specialized training.

Perceptions of the Problem

Respondents were asked to comment on the severity of the problem of domestic violence, to identify factors which may contribute to the problem, and to identify other problem areas frequently experienced by battered women. The vast majority of respondents across all DHHS funded programs, at both the State and community level, believe that domestic violence is a severe problem. Most respondents also believe that economic factors such as financial stress and unemployment are an underlying cause. State and community respondents tend to agree less often with regard to other underlying factors. State level respondents identified societal factors (such as sex role stereotypes and the changing role of the family) second only to economic factors, whereas local respondents more frequently commented on the presence of substance abuse, particularly alcoholism, as a factor related to spousal abuse. Familial factors such as learning abusive behavior within the family, personal factors such as emotional difficulties and stress, and interpersonal factors, such as communication problems, were generally identified with the same frequency by State and local respondents.

Data show that most staff of DHHS funded programs recognize spouse abuse as a severe and complex problem requiring the local provision of many different services. Respondents also perceive their communities as having insufficient resources to meet the service needs. The following section discusses additional barriers identified by respondents as restricting their programs from filling the gaps in the service delivery system.

Barriers to Service Delivery

Program respondents identified multiple barriers which they believe restrict their programs from responding to the needs of battered women and their families. Some of these barriers are viewed as resulting from Federal and State legislation and regulations. Other barriers are seen as resulting from limited program resources available to deal with the problem. Finally, there are barriers perceived as a result of community attitudes and victims' characteristics.

Respondents repeatedly noted that it is not within the purview of their programs to provide any special assistance to victims and their families. While it is true that some of the DHHS funded programs surveyed cannot target services on any special population not eligible by legislative mandate (e.g., income eligible, or eligible because of substance abuse), the mandates do not preclude staff from initiating special activities to help victims who are eligible for basic program services.

Respondents from several programs, particularly the WIN, Community Mental Health Centers, Alcoholism Treatment and Drug Abuse programs, noted that Federal and State regulations on financial reimbursement restrict them from

helping battered women and their families. Some WIN respondents, for example, reported that there are no reimbursable service categories related to the problem of domestic violence. Drug Abuse program respondents reported that services extended to family members of substance abusers often are not reimbursable. Thus, respondents from these programs commenced that battered women whose husbands are the substance abusers usually are not provided with any direct program services.

Respondents also noted that several DHHS funded programs have established separate processes for determining an applicant's financial eligibility and service eligibility. Many respondents perceive that strict interpretation of this policy deters the identification and referral of battered women by income maintenance staff. Many respondents also believe that they are deterred from referring victims to other programs because of issues related to client confidentiality.

The limited availability of program resources is viewed as another major barrier to serving battered women. Funding and staffing shortages already curtail activities in ongoing mandated program areas; most program respondents consider the commitment of additional funding and staff as necessary prerequisites to expanding services to battered women and their families.

Community attitudes apparently further restrict DHHS funded programs' capacity to assist battered women. Repeatedly, community resistance to intervening in "private" family life was noted by respondents. Such community attitudes apparently extend into the service provider network as well.

Many respondents noted barriers to service delivery created by the battered woman's personal situation. For example, battered women with no children are not eligible for AFDC, Emergency Assistance, Child Welfare Services, Child Protective Services, or WIN program services. In addition, battered women must meet the income, residency, and/or other types of eligibility criteria specified by the DHHS funded programs. This means that while similar basic services are needed by most battered women, eligibility for those services has to be determined on a case-by-case basis. This is a time consuming task which most agency staff are not mandated to assume.

Further, many respondents believe that battered women are generally reluctant to seek program services, because they are afraid of their spouses' reaction, are too embarrassed to admit to being battered, feel there is a stigma attached to receipt of "welfare" or "psychiatric" services, or are afraid that their children will be placed in foster family homes. Other respondents believe that battered women often are unaware of services available, or have no means of transportation to programs offering the services they need.

Finally, one significant barrier, reported by more than one-half (51%) of the DHHS funded program respondents at the community level, is that their programs have no intake procedures for identifying battered women. Thus, battered women and their families are not routinely identified or referred to other service providers.

In brief, a variety of barriers are perceived by respondents as interfering with the development of program strategies to assist victims of domestic violence and their families. Some of these barriers result from actual constraints on program resources, lack of community support, or lack of staff knowledge on how to identify and intervene with victims and abusers. Other barriers, however, stem from staff misinterpretation of program mandates, policies, and regulations. Clarification of these latter areas by Federal and State administrators appears to be a significant prerequisite to further use of DHHS program resources for victims.

Some DHHS funded programs surveyed are able to address the needs of battered women in spite of the barriers noted above. In addition, program respondents offered other suggestions for resolving barriers to service delivery. These recommendations are discussed in the next section.

Respondent Recommendations to Enhance Service Delivery

Program respondents were asked to suggest methods for overcoming barriers and improving the delivery of services to victims and their families. Suggestions often relate to changes in: 1) program mandates, regulations, and resources; 2) internal program policies and procedures; 3) interagency linkages; and 4) training and technical assistance activities.

Many respondents expressed the need for changes in current program mandates, regulations, and resource allocation to enable direct service provision and other activities on behalf of battered women and their families. They suggested: 1) revision of program mandates to permit and/or encourage the targeting of DHHS activities on victims of domestic violence; 2) revision of program regulations to allow Federal reimbursement for services to all members of a client's family; and 3) clarification of issues of client confidentiality with respect to reporting cases of spouse abuse and sharing information with other service providers. In addition, nearly all respondents emphasized that their programs need additional resources (funding and staff) to focus specifically on the service needs of battered women and men, abusing spouses, and their children.

Recommendations regarding internal program policies and procedures primarily pertain to changes at the local program level. Respondents recommended the establishment of agency intake policies, which require probes for the identification of spouse abuse as well as procedures to follow once the problem is identified. When spouse abuse is the presenting problem, they suggest speeding up the application process or waiving some of the eligibility requirements which may place her in further danger (e.g., pursuit of child support, returning home to obtain documents necessary for verification of assets, birth records, etc.).

Appointing staff as domestic violence intervention and referral specialists is another suggestion made to facilitate the program's responsiveness to victims and their families. Several respondents believe that the development/expansion of crisis intervention, family treatment, and group counseling approaches within their agencies would further facilitate the delivery of services to battered women.

Respondents also have suggestions for improving interagency linkages and the coordination of services provided by various agencies. Although they recognize that battered women have a range of service needs, many respondents suggest that one agency be designated as the focal point of domestic violence intervention. This State/local agency would assume primary responsibility for community and professional education, service coordination, and direct intervention. In addition, this agency would help staff from other programs to clarify their roles and options in domestic violence cases. Staffing and funding from various programs could be combined to provide this agency with resources needed to carry out its activities. Further, respondents suggest that formal referral and follow-up procedures on behalf of victims and their families be developed among agencies.

Finally, respondents suggest that program staff receive training/technical assistance to improve their capacity to intervene with families experiencing domestic violence.

State and Local Domestic Violence Program Initiatives

State funded and grassroots programs are making important contributions to the delivery of services for victims and their families. Often, these programs are providing services, such as emergency housing and specialized crisis intervention, which are not available elsewhere in the community. Staff also are providing services to abused spouses who are not eligible for DHHS program services. Program staff are increasing community and government awareness of the special service needs of victims.

Victims of domestic violence, in turn, are increasingly turning to both the special programs and DHHS funded programs for help. Staff of the DHHS programs surveyed view the specialized programs as critical referral resources for their clients. It appears that the resources of both are necessary if victims' needs are to be met, even partially.

One must remember that these special programs do not exist everywhere. We estimate from our findings that nearly one-half of the communities across the country have no special programs, not even hotlines or crisis intervention programs, for battered spouses. Further, many of the special programs which do exist are experiencing severe financial difficulties. Services for children and abusing spouses are virtually undeveloped.

Summary

Study findings indicate that most staff of DHHS funded programs are aware of the problem of spouse abuse, its complexity, and the special needs of victims. They also recognize that many service needs of victims are not being met through existing community resources. These findings, coupled with the findings related to State and local domestic violence programs, reinforce the fact that there is no one program which can meet all the service needs of victims and their families. Rather, the challenge ahead is learning how to make better use of existing program resources available through Federal, State, and local auspices.

FINAL REPORT

The Final Report includes five chapters and two supplemental reports which are bound separately. Chapter 1 of the Final Report includes a discussion of the problem of domestic violence and a detailed description of the study methodology. Chapter 2 presents the major study findings on a program-by-program basis. Examples of individual program activities related to the problems of spouse abuse are documented, as well as the barriers to service delivery and the recommendations for change identified by survey respondents. Chapter 3 provides an overview of the study findings across all programs surveyed, including recommendations from survey respondents on training and technical assistance activities that would enhance staff capacity to deal with families experiencing domestic violence. Chapter 4 explores the relationship between various types of programs and variables which potentially could influence service delivery to victims of domestic violence. Chapter 5 highlights components of the programs studied which benefit (or have the potential to benefit) victims and their families.

Two supplemental reports present study findings from different perspectives. The first supplemental report presents the major findings of the State survey on a State-by-State basis. The second supplemental report is comprised of three case studies, each of which addresses activities related to domestic violence at the community level. The first of these describes DHHS and locally funded program activities occurring across five California communities. California was selected for special study because of the extensive involvement of grassroots organizations with the problem of spouse abuse, and because of its concentrated populations of Hispanic and Asian women. The second case study examines State funded domestic violence programs in two Michigan communities, particularly with regard to how these programs evolved and developed coordination linkages with other service providers. The final case study details the domestic violence intervention activities taking place on three military bases, with an emphasis on Camp Pendleton, a marine base in California.

INTRODUCTION

This study, initiated by the Department of Health and Human Services (DHHS) in October 1979, and conducted by CSR, Incorporated, provides information on where and how selected DHHS, State, and locally funded programs are making services available to victims of domestic violence. Although domestic violence may refer to any physical, sexual, emotional, and verbal abuse occurring between or among members of the same household, this study focuses on women who are abused physically by their partners. To a lesser degree, the study also focuses on the children of battered women, battered men, and abusing spouses. This study does not focus on abused children.

In addition to determining the scope of program activities related to the problem of domestic violence, this study identifies barriers to service provision as well as the potential of program staff to resolve barriers and provide services to victims. Data related to these study areas were obtained primarily through two major survey efforts. The first survey, the State Survey, occurred between April and June 1980, and included telephone interviews with State level program administrators in every State and the District of Columbia. The second survey, the Community Survey, occurred between July and September 1980, and included personal interviews with local program administrators and direct service providers in 88 communities. (Interviews in an additional eight communities were conducted for supplemental analyses.)

The DHHS funded programs selected for these two surveys have no Federal mandate to provide services especially for abused spouses and their families. Rather, the selected DHHS funded programs are Federally legislated and authorized to serve income eligible and other special populations. These broader service populations, however, may include victims of spouse abuse, many of whom could benefit by special intervention from program staff.

While working within the framework of their programs' present legislative authorizations, some State and local staff of DHHS funded programs are already taking steps to recognize and address the service needs of these victims. This study documents these efforts, providing examples for other States and communities to follow. Further, some States and communities have developed special programs for abused spouses and their families and/or have expanded existing human service programs, including those funded by DHHS, to better meet the needs of victims. Some States have passed legislation related to domestic violence and some have engaged in other State initiatives toward becoming more responsive to victims' needs. Thus, this study also offers the opportunity to report on these efforts and to learn from them.

Within this context, DHHS anticipated that study findings on program activities at both the State and community level would:

- Allow for DHHS dissemination of information on seemingly effective and efficient methods of service delivery to victims of domestic violence.

- Assist DHHS identification of barriers to domestic violence service provision which occur at the State or community level and which can be eliminated only by action at these levels.

- Provide DHHS with information which would support decisions on whether changes should be made in DHHS funded programs, or whether DHHS should assume other activities in conjunction with State or local agencies and organizations to provide services to victims of domestic violence.

This report includes five chapters, and two supplemental reports which are bound separately. Chapter 1, "Study Overview," summarizes the problem of domestic violence and the study's design, methodology and data limitations. Chapter 2, "Major Study Findings," presents the State and Community Survey findings, in detail, on a program-by-program basis. Examples of individual program activities related to the problem of spouse abuse are documented, as well as the barriers to service delivery and the recommendations for change identified by survey respondents. Chapter 3, "Study Findings from a National Perspective," provides an overview across all programs surveyed, including recommendations from survey respondents on training and technical assistance activities that would enhance staff capacity to deal with families experiencing domestic violence. Chapter 4, "Special Analyses of State and Community Survey Findings" explores the relationship between various types of programs and variables which potentially could influence service delivery to victims of domestic violence. Chapter 5, "Strategies for Service Delivery" highlights components of the programs studied which benefit (or have the potential to benefit) victims and their families.

The two supplemental reports address more specific aspects of the total study effort. The first supplemental report presents the major findings of the State Survey on a State-by-State basis. Each State has its own profile which describes, from the perspective of State administrators, State and program activities related to the problem of domestic violence. The second supplemental report is comprised of three case studies, each of which addresses activities related to domestic violence at the community level. The first of these describes DHHS and locally funded program activities occurring across five California communities. California was selected for special study because of the extensive involvement of grassroots organizations with the problem of spouse abuse, and because of its concentrated populations of Hispanic and Asian women. The second case study examines State funded domestic violence programs in two Michigan communities, particularly with regard to how these programs evolved and developed coordination linkages with other service providers. The final case study details the domestic violence intervention activities taking place on three military bases, with an emphasis on Camp Pendleton, a marine base in California.

Chapter 1 which follows provides the framework for subsequent discussions on study findings.

CHAPTER 1: STUDY OVERVIEW

STATEMENT OF THE PROBLEM

Public concern about violence in the family has increased over the past several years. This concern was directed first on helping abused children. Now, there is growing concern about providing help to abused spouses and their families.

Spouse abuse is not a new phenomena. It has always existed.[1] However, the public and victims, themselves, have just recently turned to legislators, administrators, and service providers for help with the problem. Individuals within the legal and human services systems at Federal, State, and local levels are seeking a response to this new demand for assistance.

Although the exact extent of spouse abuse is not known, there is evidence that the problem is widespread. Where special programs for victims and their families exist, the requests for services exceed the available program resources. Estimates on the number of victims of domestic violence in the United States vary, ranging from 1 million to 28 million.[2] A recent national survey funded by the National Institute of Mental Health (NIMH) resulted in a projection that over 1.7 million wives are severely abused per year.[3] Straus qualifies this estimate by suggesting that "the true incidence rate for any use of violence in a marriage is probably closer to 50 to 60 percent of all couples..."[4] The findings of these and other studies emphasize both the seriousness of the problem as well as its prevalence across all social, economic, and racial/ethnic groups in all geographic areas.

Several themes relating to the conditions and causes of wife abuse recur throughout the literature. Much of the literature focuses on the societal conditions which have sanctioned abuse. For example, the legal system and

[1]Davidson, Terry. Conjugal Crime: Understanding and Changing the Wife Beating Pattern. New York, Hawthorne Books, 1978, pp 95-113.

[2]Jacobson, Beverly. "Battered Women." In Civil Rights Digest, Vol. 9, No. 4, 1977, pp 2-11.

[3]Straus, Murray; Gelles, Richard; and Steinmetz, Suzanne. Behind Closed Doors: Violence in the American Family. New York, Anchor Press, 1980.

[4]Straus, M. A. "Wife Beating: Causes, Treatment and Research Needs. In Battered Women: Issues of Public Policy. U.S. Commission on Civil Rights, Jan. 1978, p. 467.

laws relating to the marital institution historically have condoned the husband's physical violence toward his wife.[5] Further, the general acceptance of violence as part of our society has perpetuated the manifestation of violence in the family unit.[6] Research has indicated that the acceptance or use of interpersonal violence by an adult is related to the extent to which an individual initiates, receives or observes interpersonal violence as a child.[7] A recent NIMH study found that "the sons of the most violent parents have a rate of wife-beating 1,000 percent greater than that of the sons of non-violent parents."[8]

Other researchers focus on the problem of domestic violence as reflecting the overall status of women in society and their lack of political, economic, and social power.[9] From this perspective, spousal abuse is viewed as only one of many actions which are used to subordinate women in our society.

The conditions and characteristics associated with domestic violence can be viewed two ways. First, studies have focused on the correlation between specific variables or factors and the incidence and severity of violence. For example, research has shown that the use of alcohol is correlated with family members' inflicting violence on their spouses and children.[10] Walker determined that the "most violent physical abuse was suffered by women whose men were consistent drinkers."[11] Gil found that stress related to temporary or chronic unemployment and underemployment is characteristic in violent

[5]Eisenberg, S. E.; and Micklow, P. L. "The Assaulted Wife: 'Catch 22' Revisited." In Women's Rights Law Reporter, Vol. 3, 1977, pp. 138-161.

[6]Steinmetz, S. K.; and Straus, M. (eds.) Violence in the Family. New York, Dodd, Mead & Co., 1974.

[7]Owens, D. J.; and Straus, M. A. "The Social Structure of Violence in Childhood and Approval of Violence as an Adult." In Aggressive Behavior, Vol. 1, 1975, pp. 193-211.

[8]Strauss, et al. Behind Closed Doors, p. 101.

[9]E.g., Martin, Del. Battered Wives. San Francisco, Glide Publications, 1976; and Pagelow, M. D. "Secondary Battering: Breaking the Cycle of Domestic Violence." Paper presented at American Sociological Association, 1977.

[10]E.g., "Alcohol and Domestic Violence." In Response, Vol. 2, No. 3, Jan. 1979; Gelles, R. J. The Violent Home. Beverly Hills, CA, Sage Publications, 1974.

[11]Walker, L. E. The Battered Woman, Harper and Row, New York, 1979, p. 25.

families.[12] Gelles[13] and Steinmetz[14] found a high correlation between previous experience with violence and violence committed as an adult. Also, in families where child abuse and neglect are identified, spousal abuse often exists.[15]

A second way of viewing conditions related to domestic violence is to look at why many women who are abused continue to remain in the violent home, or, after attempting to leave home, return. Del Martin suggests asking the question, "What is it about marriage and society that keeps a woman captive in a violent marriage?"[16] Various researchers have examined the stated reasons for women staying in violent situations. These reasons include:

- Fear for one's own or the children's safety.
- Lack of, or perceived lack of, police protection.
- Lack of financial resources and economic dependence on the spouse.
- Feelings regarding the children's welfare (e.g., children need a father; no means to support the children on one's own).
- Cultural and societal expectations (e.g., social approval of marriage and disapproval of "broken homes").
- Knowledge of the traditional non-intervention of government, community, friends, and extended family into "marital problems."
- Physical and social isolation.
- Lack of knowledge regarding legal rights and possible legal options.
- Previous unsuccessful attempts in seeking assistance from social service agencies or from the criminal justice system.

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[12] Gil, D. G. Violence Against Children. Cambridge, MA, Harvard University Press, 1970. Gil reported that close to 50% of fathers who were abusers experienced unemployment in the year preceding the abuse.

[13] Gelles, R. J. "Abused Wives: Why Do They Stay?" Journal of Marriage and the Family, Vol. 38, No. 10, 1976.

[14] Steinmetz, S. K. "The Cycle of Violence: From Family to Society." In The Cycle of Violence: Assertive, Aggressive and Abusive Family Interaction. New York, Praeger, 1977.

[15] Gayford, J. J. "Wife Battering: A Preliminary Survey of 100 Cases." In British Medical Journal 1(5951):194-197, 1975.

[16] Martin, Del. "Overview--Scope of the Problem." In Battered Women: Issues of Public Policy, U.S. Commission on Civil Rights, 1978, p. 216.

These conditions and characteristics suggest that the problem of domestic violence cannot be ignored. In interpreting the findings of this study, we are concerned not only with what is being done currently to serve victims, but with what mechanisms and forums are appropriate and best suited to deal with the problem in the future.

SIGNIFICANCE OF THIS STUDY

The service needs of battered women extend to nearly every aspect of their personal and family life--physical and mental health, economic security, legal protection, interpersonal relationships, and general well-being. Overall, the human service delivery system can play a key role in providing the services and resources required by battered women. The DHHS funded programs under study represent a major portion of the human services system already existing in every State. These programs have the potential to help meet the comprehensive service needs of victims and their families.

In some of the States or communities surveyed, staff are addressing the needs of victims and their families through DHHS program resources. These efforts are discussed in this report so that they may provide guidance to State and local staff working in or with DHHS funded programs elsewhere. Program barriers to serving abused spouses and their families, as perceived by State and local staff, are documented herein to assist program staff in developing resolutions to these constraints.

Despite the apparent potential of DHHS programs to assist victims of domestic violence and their families, some victims are not eligible for DHHS program services and/or their needs extend beyond DHHS program resources. This study's examination of State funded and community based domestic violence programs, therefore, provides data on how staff from these specialized programs are filling some of the gaps in the service delivery system. Moreover, as staff from various DHHS, State, and locally funded programs are provided with knowledge about each other's program strengths and limitations, they also can learn how to supplement each other's resources more effectively.

STUDY DESIGN

From among the many possible DHHS funded programs to survey, the following DHHS programs were selected for this study.

DHHS Program	Authorizing Legislation
• Aid to Families with Dependent Children	Social Security Act, Title IVA
• Emergency Assistance	Social Security Act, Title IVA
• Child Welfare Services	Social Security Act, Title IVB

• Medical Assistance (Medicaid)	Social Security Act, Title XIX
• Social Services*	Social Security Act, Title XX
• Child Abuse and Neglect Prevention and Treatment	Child Abuse Prevention and Treatment Act
• Community Health Centers	Public Health Services Act, Title III, Section 330, as amended
• Community Mental Health Centers	Community Mental Health Centers Act of 1975, Title III, Public Health Services Act, as amended
• Indian Health Services	Indian Self-Determination Educational Assistance Act
• Work Incentive Program	Social Security Act, Amendments of 1967
• Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970
• Drug Abuse Demonstration and Community Service Programs	Drug Abuse Office and Treatment Act of 1972, as amended.

This selection of programs by DHHS is based on three primary factors. First, the total range of services offered by these programs appears to have the most relevance to the known service needs of abused spouses and their families. Financial assistance, medical care, counseling, and employment-related services are needed frequently by battered women. Second, as most of these DHHS programs exist in every State, staff have the potential for identifying victims and providing direct services and/or referrals to other programs. Third, these programs represent a potentially rich resource for the collection of information on the scope of the problem and the demand for services.

In addition to the DHHS funded programs, DHHS also requested that State and local programs on domestic violence and local shelters for battered women be included in the study sample. Further, when "close and substantive working relationships" related to the problem of domestic violence were identified between the surveyed DHHS funded programs and other Federal or private programs, these other programs were surveyed as well. DHHS requested that representatives of State Coalitions Against Domestic Violence and various grassroots organizations be contacted prior to initiation of the State Survey

*For the purposes of this report, child protective services provided through Social Services (Title XX) are addressed as a distinct program component, Child Protective Services.

to document their efforts on behalf of battered women and their perspectives on the service delivery system.

DHHS provided 14 research questions to guide this study's review of program activities related to victims of domestic violence.

- Have victims of domestic violence been identified as a specific target population in need of services?
- Are there any implicit or explicit policies regarding services for victims of domestic violence? If yes, what are they?
- Has the agency identified any practices, interpretations of language in statutes, regulations, or guidelines which inhibit or enhance service delivery to victims of domestic violence? If yes, what are they? If such practices or interpretations pose barriers to service delivery, have any actions been taken to make the necessary changes?
- Are there other types of barriers to services perceived by the agency?
- Is there a mechanism for coordination with other programs, including shelters which engage in service delivery or advocacy activities for victims of domestic violence? If yes, what is the mechanism? What kinds of administrative, outreach, or other arrangements are used to coordinate and maximize service delivery? Does the agency perceive these arrangements as effective?
- Are there any special programs for victims of domestic violence or services for which domestic violence victims have group eligibility? What are these programs and what services are offered?
- Which Federal programs and funding sources actually provide assistance to victims of domestic violence and how extensive is the provision of services?
- Which programs potentially could provide assistance to victims of domestic violence?
- What barriers exist, if any, which limit a program's responsiveness to the needs of battered women?
  - -- barriers resulting from Federal, State, and local legislation, regulations, ordinances, policies, and guidelines?
  - -- barriers resulting from Federal, State, or local interpretation of program objectives and functions?
- Are there service needs for victims of domestic violence which providers believe are not being met through existing programs?

- Are there programs or activities which have been undertaken at the State or community level which appear to have potential for increasing service delivery to victims of domestic violence in other localities?

- Are there any advocacy groups which the agency believes have had an impact on the delivery of services to domestic violence victims? Has that impact been negative or positive?

- Is there information available as to the number of victims of domestic violence served and the cost of these services?

- What is the agency definition of domestic violence? Is this definition used to determine service eligibility?

Based on a review of these questions, three primary study objectives were developed: 1) to assess the extent to which staff from the selected programs provide assistance to battered women and their families; 2) to identify legal and/or administrative constraints of programs which affect the extent to which staff serve this population; and 3) to identify other factors which have an effect on service provision, for example, staff opinions and community characteristics.

STUDY METHODOLOGY

Two distinct surveys were conducted to obtain the data required to address the study questions: a State level survey and a community level survey. Major findings from the State Survey also were used as the basis for selecting the States to be included in the Community Survey. The sampling plans, questionnaire designs, respondent selection, and study procedures for each survey are described as follows.

The State Survey

Since two of the selected DHHS funded programs, Child Abuse Prevention and Treatment, and Community Health, provide grants directly to communities and do not have corresponding State level administrations, it was inappropriate to include them in the State Survey sample. However, all the other DHHS funded programs, with isolated exceptions, were operative in every State and the District of Columbia. Thus, since all programs were surveyed, there was no need to develop a sampling plan.

The questionnaire which was developed for the State Survey restricted the data collection to information:

- Describing staff activities to assist battered women and their families and the barriers to service delivery.

- Identifying special State domestic violence initiatives, the services provided, and the administrative structure of service provision.

- Describing substantive interaction among DHHS funded programs and other Federally or privately funded programs.

This approach ensured that the full range of DHHS funded program activities directed on the problem of spouse abuse would be documented as well as State activities targeted especially on victims. The questionnaire, in final form, was organized into five major areas: 1) program/respondent data, 2) policies and responsibilities, 3) barriers and facilitators, 4) services, and 5) linkages.

The questionnaire and State Survey procedures were pretested in Delaware and West Virginia in November, 1979. In addition, a detailed Procedural Manual was developed to supplement the questionnaire. This manual provided CSR interviewers with protocol and clearance procedures, a glossary of survey terms, and program specific probes for use during the administration of the questionnaire. The study's technical consultants and Advisory Board members also reviewed the questionnaire and suggested revisions which were incorporated into the final version.

The State Survey, conducted by telephone, was initiated in March 1980, immediately following clearance from the Office of Management and Budget (OMB). Letters describing the State Survey and requesting permission to proceed were sent to every Governor and the Mayor of the District of Columbia. All interviewers were selected from central office CSR staff and they received two days of initial training plus weekly follow-up training. The interviewers made a series of calls to Governors, department commissioners/directors, and top and sub-level State program administrators to obtain final clearance for the Survey and to identify potential respondents. Individuals selected as respondents were "screened" by referral sources and CSR staff on the basis of two criteria: 1) most knowledgeable of the selected program's policies, procedures, regulations, and services; and/or 2) most knowledgeable of the selected program's activities related to the problem of domestic violence. The findings reflect a composite viewpoint of each program's activities. Administrators from a total of 484 programs were interviewed; the response rate for the State Survey was 98 percent.

The Community Survey

The sampling plan for the Community Survey involved three distinct steps: 1) development of a classification system for the States; 2) stratification of States according to geography and level of service activity for victims of domestic violence as reflected by the State survey data; and 3) selection of 15 States and 88 communities within the selected States, the latter based on a random probability sampling approach.* Each of these steps is described more fully in subsequent paragraphs.

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*A total of 96 communities were surveyed for this study. However, the findings from eight of these communities are analyzed separately in two case studies. One of the case studies pertains to the Rosebud and White River Indian Reservations (included in the next Chapter) and the other to the sample of five communities in California (included in a supplement to this Report).

Upon completion of the State Survey, CSR developed a system of classifying the States with regard to several criterion variables. These variables included: 1) the presence/absence and/or comprehensiveness of State legislation on domestic violence; 2) the existence of and activity level of a State Coalition Against Domestic Violence; 3) the presence/absence of a State authorized and funded program on domestic violence; 4) responses to specific questions asked of program respondents; and 5) the interviewer's assessment of the level of program activity directed toward the problem of spouse abuse. The questions, which were used as criterion variables, addressed the extent of program involvement in assisting battered women and their families through program emphases and goals, direct services, coordination activities, staff training, and technical assistance.

Based on the above variables, activity level scores were computed for each State and the District of Columbia. These scores were placed along a continuum to determine the range of variation and clustering of scores. The States then were assigned to one of twelve categories, representing the Census Bureau's four major geographic regions (Northeast, South, North Central, and West) and activity level classifications (active, in-between, and inactive). In turn, 15 States, representative of the nation, were selected from the categories for inclusion in the second major survey, the Community Survey. The 15 States selected for the Community Survey were: Alabama, Arizona, Kentucky, Maine, Michigan, Missouri, Nebraska, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Utah, and Vermont.*

From the 15 States, 88 communities were selected for in-depth, face-to-face interviews with local program administrators and direct service staff. Community was defined as "a county, or an independent city."

There were two major considerations in constructing the sample of communities (sites). First, the process was designed to meet the requirements delineated in the Request for Proposal. These requirements were: at least three sites had to be selected in each State and at least five programs had to be surveyed at each site; and, in the entire sample, five sites had to be rural, two sites had to include a substantial military population, and two sites had to be Indian reservations. Second, the process had to ensure a representative cross-cutting of communities with different population characteristics. The procedures developed for selecting the communities for survey utilized a random probability sampling approach which took into account these considerations.

A matrix of all programs under study located in each of the 88 communities was prepared. Specific programs in each community then were selected randomly for inclusion in the survey. The number of programs initially selected across the sites totaled 490. The number of DHHS funded programs sampled across all 88 communities ranged from 25 to 47, except for the Indian Health Services and Child Abuse Prevention and Treatment programs which had four and six local programs, respectively.

*In addition to these 15 States, South Dakota was purposely added to the State sample to exemplify activities undertaken on behalf of battered women and their families by the Rosebud Indian Reservation and its surrounding community, Todd County. California also was purposely added to exemplify activities performed by various local programs on behalf of battered women, especially minority women.

A pretest of the Community Survey procedures and questionnaire also had been conducted in Delaware and West Virginia in November 1979. Revisions then were incorporated into the final version of the community questionnaire. Its content, patterned after the State questionnaire, included additional questions seeking more in-depth information about program practices related to intake procedures and assessment of clients, as well as data on clients identified as battered women. As with the State Survey, an Interviewer's Procedural Manual and program specific probes were developed and used during the administration of the structured questionnaire.

Prior to the initiation of any direct contacts in the selected States and communities, letters describing the Community Survey were sent to the Governors, State program administrators, and local program administrators. Forty-five field staff were recruited and trained on the Community Survey clearance and interview processes. Field staff resided in or near the communities assigned to them in the majority of instances.

One administrator and (up to) three direct service staff were interviewed in each program selected within a community. CSR central staff consistently monitored the field staff's work by making site visits, accompanying field staff on interviews, reviewing completed questionnaires, and calling field staff for weekly progress reports.

The field work for the Community Survey was initiated on July 17, 1980, with September 8, 1980 established as the target date for completion. A total of 444 programs, with interviews from 1,313 respondents, constitute the computerized data base. The distribution of the 1,313 respondents, according to job functon, is: 368 administrators, 724 direct service staff, and 221 staff who function in both capacities.

In the eight sites selected for special analyses, interviews with administrators and direct service staff from another 45 community based programs took place over the same period of time. As noted earlier, the findings from these interviews are treated separately in the supplemental case study report and in a report on domestic violence intervention activities on two American Indian reservations which follows the Indian Health Services program description in Chapter 2.

DATA LIMITATIONS

In undertaking the survey efforts, CSR staff recognized two major factors which influenced the conduct of the work. First, the DHHS funded programs under study show considerable variation in the allocation of funds and administrative structure from State to State. For example, Social Services (Title XX) is often a major source of funding for the services offered to clients by AFDC, Child Welfare Services, and Work Incentive program staff. In attempts to clarify program funding amounts and sources, CSR learned that program respondents (and even State finance officers) often did not know which (or how) DHHS monies flowed into specific State programs. Although these variations were

addressed, to the degree possible in the study design, their actual effect on the delivery of DHHS funded services to victims and their families requires further analyses.

Second, as Community Survey efforts were undertaken, program additions and substitutions in the original sample were made. Additions occurred when interviews with local DHHS funded program staff revealed "close and substantive working relationships" with other community programs, or revealed the existence of programs in the community focusing on a unique aspect of service delivery (for example, a program that provides help for abusing spouses). Program substitutions were made when the programs/projects originally identified for the Community Survey were no longer in existence or had lost their Federal funding. Additionally, in Michigan, planned interviews with local staff from programs funded by the Michigan Department of Social Services (DSS) were cancelled at the request of the State. The State Department of Social Servies was concerned that local staff were experiencing an upsurge in work loads due to Michigan's growing rate of unemployment, and, therefore, did not have time to participate in the Community Survey. However, CSR was given approval by the Michigan DSS to proceed with interviews with staff working directly in DSS sponsored domestic abuse programs. Interviews in Michigan with staff from other departments were conducted as planned. The data collected in these interviews are integrated into the overall data base analyzed in this report.

In addition, it is important to note that the scope of this study did not include extensive research of the enabling legislation and regulations of the selected DHHS funded programs surveyed. Generally, States have flexibility in interpreting the DHHS program mandates as evidenced by the survey findings on staff activities aimed at assisting victims of domestic violence. Additional clarification by DHHS and State administrators, however, may be necessary with regard to some respondents' perceptions of Federal and/or State barriers to service delivery.

Finally, the scope of the study did not include any questions asked directly of victims and their families to gain their perspectives on the problem, the effectiveness of current services, and unmet service needs. However, during the course of the survey, some DHHS funded program staff, as well as domestic violence program staff, acknowledged their own personal experiences with the problem. Although their opinions, as respondents, are integrated into the data base, a much more thorough study of victims' perspectives on and experiences with service providers is warranted.

Each of the DHHS programs surveyed is discussed separately in the following Chapter. Then, Chapter 3 presents an overview, across all the DHHS funded programs studied, of program activities related to the problem of spousal abuse.

CHAPTER 2: MAJOR STUDY FINDINGS

This chapter provides detail on the major findings of the study on a program-by-program basis. As applicable, findings from the State Survey, the survey of State level program administrators in every State and the District of Columbia, are coupled with the findings from the Community Survey, the in-depth survey of local program administrators and direct services staff in 88 communities/15 States. The findings are organized into distinct program reports:

- Aid to Families with Dependent Children
- Emergency Assistance
- Child Welfare Services
- Child Protective Services
- Child Abuse and Neglect Prevention and Treatment
- Medical Assistance (Medicaid)
- Community Health Centers
- Social Services (Title XX)
- Work Incentive
- Indian Health Services
- Community Mental Health Centers
- Alcohol Formula Grants and Alcoholism Treatment and Rehabilitation Programs
- Drug Abuse Demonstration and Community Service Programs
- State Funded Domestic Violence Programs
- Other Domestic Violence Programs/ Shelters for Battered Women

In addition, a case study which presents Community Survey findings related to domestic violence intervention activities on two American Indian Reservations follows the Indian Health Services report.

In reviewing the reports of DHHS funded programs, it is important to remember that the programs surveyed are under no Federal mandate to engage in special efforts related to the problem of spouse abuse, nor is this study intended to be an evaluation of program performance. Rather, the reports

reflect the extent to which States and communities independently have recognized and responded to the problem, using existing DHHS program structures and resources. Within each DHHS program report, examples are provided that demonstrate how State administrators and local service providers have responded to the needs of abused spouses and their families, while remaining within the parameters of their programs and without a Federal mandate to do so. Further, in some States and communities, new programs have been established specifically to address the needs of spouse abuse victims. The reports on these special programs provide the opportunity to learn more about specialized domestic violence intervention activities, including the current and potential coordination of activities with DHHS funded programs.

Study findings are organized similarly for each program. The presentation begins with an overview of the program's purpose, eligibility requirements, and primary services. This overview is followed by a statistical abstract of study findings to summarize the extent to which the program has addressed the problem of spouse abuse. For example, the abstract presents the percentage of programs at the State and community levels which have: estabished definitions of domestic violence; established goals/objectives related to the needs of battered women; and engaged in activities to assist battered women.

Following the abstract of program findings, the potential of the program to address the needs of abused spouses is explored through discussions on: 1) specific program efforts related to battered women and their families, 2) barriers to service delivery (as identified by program respondents), and 3) recommendations from program staff to enhance service delivery. These three areas, together, reflect program potential by illustrating the current "state-of-the-art," identifying the range of barriers which staff perceive as restricting them from being more responsive to victims, and by pointing out the changes necessary to increase staff efforts on behalf of victims and their families.

At the end of this Chapter, the first in a series of tables is presented to enable comparison of statistical findings across 11 of the DHHS funded programs surveyed. The Indian Health Services and Child Abuse Prevention and Treatment Programs are omitted from the tables because their administrative structures and study samples do not lend themselves to comparison. Findings from the State funded and other domestic violence programs surveyed also are omitted from the tables due to the lack of comparable data. However, complete study findings for these four programs are presented in their respective reports.

THE AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM (AFDC)

AUTHORIZING LEGISLATION

Title IV-A, Social Security Act

FEDERAL AGENCY RESPONSIBLE

Office of Family Assistance, Social Security Administration, Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

The primary purpose of the AFDC program is to furnish financial assistance to needy, dependent children and the parents or relatives with whom they live. The target group is children whose parents or other related caretakers have insufficient income to meet the basic needs of the family. AFDC is available to families based on the absence, death or physical or mental incapacity of a parent or relative with whom a needy child is living. Twenty-two states also provide assistance to intact families when deprivation is the result of parental unemployment (this provision is referred to as AFDC-U). Some States provide assistance to pregnant women (with no other dependents), while other States require that women have children to be eligible for benefits. Several States do provide assistance to women and children who are living in emergency shelter care facilities.

ABSTRACT OF MAJOR PROGRAM FINDINGS

The findings presented in this report are based on data obtained from interviews with State level AFDC program administrators and interviews with AFDC program administrators and staff at the community level. Administrators from all States and the District of Columbia were interviewed for the State Survey. At the community level, a total of 40 AFDC programs across 15 States were surveyed. The following findings are based on the two surveys:

- AFDC programs in two States (4%) and in three communities (8%) have established or adopted a definition of domestic violence and have goals which specifically address battered women.
- AFDC programs in one State (2%) and in four communities (10%) provide direct services specifically for battered women.
- AFDC program staff in 12 States (24%) and in 14 communities (35%) are involved in coordination activities related to the problems of domestic violence.

- AFDC programs in four States (8%) and in four communities (10%) have staff who have received training to better understand the needs of abused spouses and their families.

- In 80 percent of the States and in 68 percent of the communities, AFDC staff are aware of the efforts of battered women's advocacy groups. Further, 14 percent of the State respondents and 25 percent of the community respondents view themselves or other AFDC staff as taking on advocacy roles to benefit victims.

- AFDC program staff in 20 States (39%) and 30 communities (75%) identified Federal or State regulations which restrict their ability to provide assistance to abused spouses and their families.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

This section examines the potential of the AFDC program to initiate and/or expand assistance to victims of domestic violence. AFDC eligibility requirements and program policies vary across States; thus, the current range of activities focused on victims and the potential replicability of these activities also vary. The discussion is organized into three areas. First, current program efforts related to serving battered women are examined and examples of these efforts are provided. Second, restrictions to service provision (as identified by respondents) are delineated. Finally, recommendations offered by AFDC program respondents for improving the service delivery system are presented.

Specific Program Efforts

Generally, the AFDC program is not involved in any special activities to assist abused spouses and their families. Very few programs surveyed have developed or adopted a definition of domestic violence. However, one program has adopted a definition which illustrates the potential for the AFDC program to help victims of domestic violence. Specifically, the definition states that a woman is eligible for AFDC in a "situation where her homelessness is due to imminent or demonstrated violence from a member of the household, which imperils her health and safety or that of members of her family."

AFDC program administrators in two State programs (4%) and three community programs reported that they have program goals specifically related to the needs of battered women. Examples of specific program goals include: extension of assistance to women in shelters, helping battered women secure a home in the community, and simplification of the application process. Program staff in 43 percent of the communities surveyed also reported that they refer abused spouses to other agencies for assistance, most often to mental health agencies or legal services and less often to employment services and special programs for battered women.

In response to the problems presented by battered women, 12 AFDC programs, representing 24 percent of the States, have staff engaged in domestic

violence program funding, collection of statistics, need assessments, program planning, training, consultation, and coordination. At the community level, staff from 14 AFDC programs surveyed (35%) reported they engage in similar activities directed toward battered women. Since financial assistance is the only mandated direct service provided by AFDC, and since AFDC staff are primarily responsible for eligibility determination, it is understandable that these percentages are not higher.

Within the AFDC program, there is the opportunity for broad interpretation of various policies. For example, some programs surveyed allow a broad interpretation of residency requirements to include any type of living arrangement (shelters, halfway houses, homes for unwed mothers, etc.) Flexibility also is allowed in the determination of an applicant's assets. In determining AFDC eligibility, some States consider only the applicant's liquid and accessible resources. Thus, in these States, when a battered woman does not have access to her own or to her husband's assets, she may still be determined eligible for AFDC assistance.*

The opportunity for flexibility in policy decisions has benefited victims in other ways as well. For example, in one State, women in shelters receive benefits within five days, whereas the usual application period is 30 days. In another State, if a woman on AFDC leaves home because of abuse, the AFDC program has a special need provision which provides additional money (above the regular grant) to cover the woman's initial care in a shelter.

Several local AFDC programs surveyed have intake and referral procedures to facilitate appropriate referrals of abused spouses. Usually these referral networks have required ongoing coordination with other social service agencies. In 12 State AFDC programs (24%) and 14 local AFDC programs (35%), staff reported they engage in coordination activities on behalf of victims.

Generally, coordination is maintained on an informal basis. For example, in one State, periodic meetings are held which include representatives of various social services agencies, the domestic violence unit, and the task force on domestic violence. In another State, staff from various income maintenance programs (e.g., AFDC, Emergency and General Assistance) meet with a battered women's advocacy group and State funded domestic violence program staff. The focus of these meetings is to ensure adequate reimbursement of shelters and financial assistance to abused spouses and their families.

In still another State, AFDC staff participate in an Intradepartmental Committee on Battered Women, which also includes representatives of the Division of Youth and Family Services, Medicaid, the Welfare Department, the Mental Health Department, and several hospitals. At the local level, some of the AFDC staff are developing linkages with shelter programs and displaced homemakers' programs.

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*According to federal AFDC requirements, all States, not just "some," must consider only net income available for current use and currently available resources.

In a few AFDC programs, staff members were identified as advocates for battered women. Respondents in seven State AFDC programs (14%) and ten local programs (25%) have been involved directly in drafting new state regulations for AFDC regarding eligibility for battered women and in presenting testimony before the State legislature on behalf of battered women. In most of the AFDC programs surveyed (80% of the State programs and 68% of the community programs), AFDC staff are aware of the accomplishments of various women's advocacy groups. The accomplishments include: increasing the States' and communities' awareness of the problem of domestic violence; developing effective referral networks; establishing shelter and other support services; initiating and/or supporting legislation benefiting battered women (e.g., changing zoning laws, implementing a marriage license tax); and providing telephone counseling and peer support. AFDC program staff engaged in the referral of battered women rely significantly on the services of these advocacy and grassroots organizations.

Barriers to Service Delivery

The majority of AFDC program respondents surveyed at both the community and State level believe that it is not feasible for AFDC to expand its role in domestic violence intervention. Program staff in 39 percent of the States and 75 percent of the communities identified specific barriers which limit AFDC's capacity to meet the needs of victims. Since AFDC eligibility requirements and program resources vary considerably across States and communities, a variety of barriers were identified by respondents.

One category of barriers identified relates to the purpose of the AFDC program which is to provide assistance to families with dependent children who need financial assistance. Therefore, the AFDC program may provide assistance only to one group of battered women--those with children. Further, in those States not having AFDC-U programs, assistance to intact families is minimal. Other barriers identified result from the individual State's eligibility requirements. For example, in some States, an applicant must provide a permanent address to be considered eligible for AFDC; thus, it is difficult for a battered woman who moves frequently and/or does not want her address known to meet this requirement. In other States, a pregnant woman without children is not eligible for AFDC assistance. In those States where the program is State supervised and locally administered, it was suggested that incorrect interpretation about eligibility requirements could result in denial of assistance to battered women. For example, State level program administrators may recognize shelters as legitimate residences while local program administrators may not.

Other barriers result from the focus and mandate of the AFDC program. Federal authorizing legislation precludes the targeting of any specific population group; rather, the primary focus of the AFDC program is on children. The AFDC program is not designed to be an "emergency" program; the State mandates that an income and assets verification be conducted, resulting in a 30 to 45-day waiting period for applicants. The AFDC program is not equipped to meet the emergency service needs presented by many battered women.

Finally, a barrier identified by most respondents is the lack of adequate program resources and funds required to assist battered women and their families. At the same time, 68 percent of the AFDC respondents surveyed noted that other resources in the community are inadequate to meet the needs of battered women.

Program Recommendations to Enhance Service Delivery

AFDC staff surveyed at the local level offered several recommendations for enhancing the program's capability to address the needs of battered women. At the State level, very few suggestions were offered. Thus, the following discussion presents primarily a community perspective. Most of the changes suggested relate to eligibility criteria and increased funding. Specific suggestions include: speeding up the application process for abused spouses; raising the payment standard, allowing the targeting of victims, lowering the staff client ratio, and allowing AFDC workers to provide social services. In addition, program respondents recommended that staff training be provided in several areas; for example, the dynamics of battering, identification of abuse, resource utilization, and interviewing skills.

SUMMARY

There is considerable variance in the type and level of response made by AFDC program staff to address the needs of battered women. This variance results from the flexibility given to States to make policy decisions. For the most part, AFDC program staff are not actively involved in assisting battered women and their families as a group in need of special attention. Approximately 50 percent of the respondents surveyed believe it is not feasible for AFDC staff to do so and many more respondents identified significant barriers which would have to be resolved before victims could be assisted directly. However, there is evidence from other respondents that some special emphasis by AFDC staff can be placed on victims of domestic violence and their families within the parameters of the existing AFDC program.

THE EMERGENCY ASSISTANCE PROGRAM (EA)

AUTHORIZING LEGISLATION

Title IV-A, Social Security Act

FEDERAL AGENCY RESPONSIBLE

Office of Family Assistance, Social Security Administration
Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

The purpose of the Emergency Assistance program is to provide temporary assistance (30 days) in order to prevent the destitution of a dependent child living with parents or relatives who are faced with financial crisis. The eligibility requirements are similar to those for the Aid to Families with Dependent Children program (AFDC) but may include families with children not otherwise eligible.

This program has the potential to provide aid to abused spouses with children who are suffering severe financial hardships. Generally, cash payments are made to the client to cover housing, food, and necessary medical supplies. In some cases, vendor payments are made directly by the program to landlords, utility companies, etc. Only 21 States and the District of Columbia have elected to provide this optional program.*

ABSTRACT OF MAJOR PROGRAM FINDINGS

The findings presented in this abstract and subsequent sections are based on interviews with staff at the State and community EA program levels. Administrators from all 21 States that have an EA program, and the District of Columbia participated in the State Survey. At the community level, administrators and staff from a sample of 30 communities participated in the study.

Based on these interviews, the following findings are reported:

- EA programs in nine percent of the States and 23 percent of the communities surveyed have developed or adopted a definition of domestic violence.

*The States operating an EA program include: Arkansas, Connecticut, Delaware, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Virginia, Washington, West Virginia, Wyoming, and the District of Columbia.

- In 14 percent of the States and 17 percent of the communities surveyed, EA staff reported a program focus on battered women and/or their families.

- EA programs in 14 percent of the States and 17 percent of the communities surveyed have goals and/or objectives which specifically address the needs of battered women.

- In nine percent of the States and 10 percent of the communities surveyed, EA programs have mandated responsibilities on behalf of abused spouses.

- In 18 percent of the States and 17 percent of the communities surveyed, EA staff provide direct services to battered women and their families.

- EA staff in 36 percent of the States and 33 percent of the communities surveyed have engaged in coordination activities related to the problem of domestic violence.

- EA staff in 23 percent of the States and 23 percent of the communities surveyed have received training to understand better the needs of victims of domestic violence and their families.

- EA respondents in 77 percent of the States and 83 percent of the communities surveyed indicated an awareness of advocacy activities on behalf of victims in their respective States and communities.

- EA respondents in 23 percent of the States and 27 percent of the communities surveyed identified themselves or other staff in the EA program as advocates for abused spouses.

- In 36 percent of the States and 80 percent of the communities surveyed, EA respondents identified restrictions, originating at the Federal or State level, which impede the delivery of services to battered women and their families.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

Although the current level of EA program activity directed toward the problem of spouse abuse is limited, as evidenced by the statistics presented above, the exceptions to this general pattern illustrate several successful strategies for assisting abused spouses and their families. The following discussion provides examples of current EA staff activities directed toward victims, service delivery barriers (as identified by respondents), and respondent recommendations for improving the delivery of services to battered women.

Specific Program Effort

EA program staff in nine percent of the States and 23 percent of the communities surveyed have established definitions of domestic violence. In

States where the program is State supervised and locally administered, the counties may develop a definition of domestic violence as part of the eligibiltiy criteria; this accounts for the higher percentage of local EA staff reporting such definitions. The following phrases are included in some EA eligibility criteria: "battered women in shelters," and "need for protective services." The general definitions used by EA programs to determine emergency/destitution also can apply to abused spouses. For example, the definitions in two States are, "a situation that places in immediate jeopardy one or more members of a family" or "being without resources to meet one's needs." Thus, the EA program appears to offer a service for which many battered women are technically eligible. However, while an applicant does not have to be eligible for AFDC or already an AFDC recipient, states may limit the program's services to this group. Further, the majority of EA programs do not use "domestic violence" as a distinct criterion for eligibility.

EA program staff reported a special focus on assisting battered women in 14 percent of the States and 17 percent of the communities surveyed. Often this involves the inclusion of "battering" as an eligibility criterion for receipt of assistance. None of the EA program staff at the State or local levels reported a focus on abusing spouses. However, EA staff from one State and one community reported a focus on battered men and staff from two State and three community programs reported a focus on children of battered women. The same programs which emphasize assistance to battered women have goals and objectives related to the problem area.

Although most programs do not focus on abused spouses, staff indicated that the intake process often includes identification of and contact with battered women. Specifically, 47 percent of the local program staff said they encounter battered women during the intake process. These program staff were asked to identify the problems most often presented by battered women; they identified other types of marital conflict and housing problems, as well as the need for legal protection.

In response to these problems, some EA program staff engage in activities on behalf of abused spouses. At the State level, two programs have mandates to serve battered women, and five programs engage in non-mandated activities related to the problem of domestic violence. At the community level, EA staff from nine of the programs surveyed engage in activities to help battered women, and three of the nine programs have mandated responsibilities. Most of the activity is in the form of direct services to victims and their families; program staff in 18 percent of the States and 17 percent of the communities surveyed provide direct services to this population.

The actions of the few program staff focusing efforts on victims and their families represent potentially effective strategies for dealing with the problem. In one State, State policy has mandated provision of food, clothing, shelter, or other temporary living arrangements to abused spouses. Other activities mandated in this State include program funding, planning, and technical assistance activities to assist victims more effectively. In a few other States and communities, special procedures have been initiated which recognize the unique circumstances of abused spouses. For example, EA funds

can be used by battered women with children who have not yet been determined eligible for AFDC. Also, less stringent verification procedures are used when the applicant is a victim of domestic violence. For example, a victim would not be required to return home to obtain necessary eligibility documentation. Other specific activities which EA program staff have assumed include referral to counseling services, provision of temporary shelter, and financial assistance to relocate the household.

Perhaps the greatest contribution EA program staff can make to serving victims of domestic violence and their families is to participate in interagency coordination activities. Currently, EA staff from eight programs at the State level (36%) and ten programs at the local level (33%) engage in coordination activities on behalf of victims. EA program staff in 23 percent of the communities and 14 percent of the States surveyed participate in informal meetings to improve the service delivery network. For example, staff in one State have meetings with the Bureau of Community and Residential Care and with shelter staff to discuss methods for confidential record keeping. In another State, EA staff participate in informal meetings with other State agency staff to coordinate services for battered women. Other activities cited by respondents include staff participation in a Statewide referral network and local coordination efforts with shelter programs.

Three State respondents and two local respondents reported that program staff participate on a task force or committee aimed at assisting battered women. In one State, a representative from the EA program is involved with an Intra-Departmental Committee on Battered Women. This Committee keeps various State agencies informed of developments concerning the issue of domestic violence and promotes information sharing among agencies.

In addition to coordination activities, a few staff indicated that they, or other EA program staff, encourage service provision to abused spouses and their families. Program staff in 23 percent of the States and 27 percent of the communities surveyed identified themselves or other program staff as being advocates for victims of domestic violence. Program staff also are well aware of other advocacy efforts on behalf of domestic violence victims; program staff in 77 percent of the States and 83 percent of the communities surveyed are aware of such advocacy activites. The impact of these external advocacy efforts, as reported by EA programs staff, is that shelters are being established and battered women are more inclined to seek assistance from their program.

Despite the activities of some EA staff, most respondents at the State level and approximately one-half of the respondents at the community level do not think it is feasible for the EA program to assume any (additional) activities for victims. Barriers to serving abused spouses, identified by EA program respondents, are examined below.

Barriers to Service Delivery

Respondents at both the State and community program levels identified barriers which they perceive as limiting the capacity of EA staff to meet the needs of battered women and their families. More barriers were cited by

respondents at the local level than by State level respondents. Several different types of barriers were cited; some barriers identified are present across most States and communities. However, because of the variation in eligibility criteria and program interpretation, other barriers are unique to specific States and communities.

Three frequently cited barriers to service delivery include program eligibility requirements, the EA program mandate, and funding limitations. Local variability exists within each category of barriers. In terms of federal eligibility criteria, an individual must have dependent children to be eligible for assistance. Further, states may limit eligibility to include only AFDC and SSI recipients. In addition, financial eligibility limitations often prohibit EA staff from assisting battered women. For example, in one State, an individual's resources must total less than $750 before the person can be considered eligibile for EA. Further, according to several respondents, eligibility determinations at the county level may differ, especially when State guidelines are not explicit. Thus, within one State there can be considerable variation in the interpretation of eligibility requirements.

Barriers specific to a State's or community's eligibility requirements also were cited. In some communities, the battered woman must have already established an independent household to receive EA. In contrast, in other communities rather than requiring the woman to establish an independent household before she applies for EA, the woman only needs to show a written promise of a rental, demonstrating her intent to establish an independent household. Another example of variability relates to the marital status. In some communities, the woman must prove that she is separated from her spouse before she can receive EA.

Another barrier to helping abused spouses emanates from the respondents' interpretation of the program mandate. Several respondents at both the State and community levels believe that it is not appropriate or legal for EA to place special emphasis on assisting battered women.

The third restriction most frequently mentioned relates to funding limitations. In addition to an overall lack of program funds, there are limitations on how much and how often assistance can be provided. These limitations are imposed by both Federal and State legislation. For example, several respondents commented that EA funds are available to clients for only one 30-day period in a year. Further, some EA programs are allotted a certain budget per quarter, and no increases are given even if demand outstrips supply. Lack of funding is related to another barrier identified by program respondents; that is, lack of staff to serve battered women.

Another barrier cited by program respondents at the local level is the lack of community resources. Almost two-thirds of the community respondents surveyed (63%) believe that community resources are inadequate; specifically, they cited the lack of housing facilities for battered women, permanent or emergency, as a major barrier to effective service provision.

Overall, several types of barriers exist, and they emanate from various sources. Generally, most of these barriers have not been resolved. However,

program staff offered some recommendations and changes that would increase the capability of the EA program to serve battered women. These recommendations follow.

Program Recommendations to Enhance Service Delivery

The recommendations offered by EA program staff represent changes which they believe would resolve some of the barriers cited earlier. Several changes were suggested:

- Make domestic violence an eligibility criteria for EA, categorically.
- Implement special procedures when spouse abuse is the reason assistance is needed; for example, process applications more quickly and provide extra funding to establish a separate household.
- Initiate staff training, specifically focusing on topics such as crisis intervention, resource utilization, identification of victims, and sensitivity to the special needs of victims.
- Increase program funding and staff.

Respondents also cited local efforts which are having a positive effect on the capacity of EA to provide assistance to abused spouses; for example, the emergence of shelters has increased community awareness of the problem and this awareness has decreased battered women's reluctance to seek help from EA. Further, some local grassroots activities have resulted in effective coordination between EA and AFDC to expedite receipt of assistance to battered women. These occurrences are exceptions; however, the recommendations provided by staff indicate that there is further potential for EA staff to assist battered women.

SUMMARY

Generally, EA program staff are not involved in activities on behalf of abused spouses. Further, almost all of the State program level respondents and one-half of the community level respondents believe it is not feasible for EA to assume any additional activities to assist battered women. Major barriers to service delivery, identified by respondents, include program eligibility requirements, the EA program mandate, and funding limitations. Since the EA program is closely related to the AFDC program, it is not surprising that similar barriers were reported by respondents surveyed in both programs.

Changes suggested by program staff to enchance the capability of the EA program to service battered women include: (1) allowing abused spouses to be categorically eligible for EA, (2) implementing special procedures for battered women, (3) conducting staff training, and (4) increasing program funding and staff. Staff from some EA programs surveyed already have taken steps to initiate the first three of these recommendations. Therefore, the potential of the EA program to assist battered women and their families may be greater than currently perceived by most of the survey respondents.

THE CHILD WELFARE SERVICES PROGRAM

AUTHORIZING LEGISLATION

Title IV-B, Social Security Act

FEDERAL AGENCY RESPONSIBLE

Children's Bureau;
Administration for Children, Youth, and Families;
Office of Human Development Service;
Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

The primary purpose of the Child Welfare Services (CWS) program is to assist children whose basic needs are not being met. Specifically, the program is to substitute for or to supplement parental care and supervision in order to:

- Prevent, remedy or assist in the solution of problems which may result from child neglect, abuse or exploitation;
- Protect or care for homeless, dependent or neglected children;
- Protect and promote the welfare of children of working mothers; and
- Otherwise protect and promote the welfare of children, including the strengthening of their own families where possible or, where needed, provide adequate care of children away from their homes in foster family homes, day care or other child care facilities.

CWS services theoretically are available to any child in need, regardless of the economic or social status of the child and/or the family. However, because program funds are limited, States and communities tend to give priority to children and families with fewest financial resources.

There is considerable flexibility in the kinds of services provided by the CWS program. States and communities typically use Title IV-B funds for services related to child protection, day care, foster family care, residential treatment, and/or adoption. The study findings presented in this discussion are limited to those States and communities which reported at least some use of their Title IV-B funding for services to children in their own homes.

ABSTRACT OF MAJOR PROGRAM FINDINGS

The study findings presented in this and subsequent sections are based on interviews with State level CWS program administrators in 35 States* and with local CWS program administrators and direct services staff in 33 communities. These figures (35 and 33) constitute the bases on which the State and community percentages have been calculated in subsequent sections of this report. Major program findings are as follows:

- In nine percent of the States and 12 percent of the communities surveyed, CWS staff reported that their programs have developed or adopted a definition of domestic violence.
- In 86 percent of the States and 33 percent of the communities surveyed, CWS staff reported a program focus on battered women, children of battered women, battered men, and/or abusing spouses.
- In 11 percent of the States and three percent of the communities surveyed, CWS staff identified program goals aimed at addressing the needs of abused spouses.
- In 49 percent of the States and 39 percent of the communities surveyed, CWS staff reported that they engage in various activities on behalf of battered women.
- In 40 percent of the States and 30 percent of the communities surveyed, CWS staff have received some training and/or technical assistance to better understand the needs of abused spouses and their families.
- In 40 percent of the States and 30 percent of the communities surveyed, CWS staff were identified as promoting assistance to battered women through advocacy efforts.
- In 91 percent of the States and 70 percent of the communities surveyed, CWS staff identified other programs, grassroots organizations or advocacy groups which direct activities on victims of spouse abuse.
- In 57 percent of the States and 64 percent of the communities surveyed, CWS staff identified barriers which restrict their capacity to address the needs of battered women.

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*In 10 States, State level CWS program administrators reported no use of Title IV-B funding for services to children in their own homes. In another six States, CWS program representatives chose not to participate in the State Survey.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

In reviewing the CWS program's potential to assist abused spouses and their families, this section describes current program activities related to the problem of domestic violence and the scope of those activities, barriers to service delivery identified by program respondents, and respondents' recommendations for facilitating the delivery of services to victims and their families.

Specific Program Efforts

CSW respondents from three States (9%) and four local programs (12%) reported on definitions of domestic violence. These definitions pertain to the criteria needed to define child abuse as opposed to other forms of domestic violence. Consequently, in one of the States and two of the communities, CWS respondents indicated that the definition limits their ability to serve abused spouses.

Ongoing CWS program efforts focused on battered women, children of battered women, battered men, and/or abusing spouses were reported in 86 percent of the State and 33 percent of the community programs surveyed. The predominant CWS emphasis is on the children of battered women at both the State (51%) and the community (33%) program levels. Although 17 percent of the CWS programs at the State level focus on battered women, none of the programs surveyed at the local level do so. In nine percent of the State and six percent of the community programs surveyed, abusing spouses receive some CWS program focus, while battered men are a focal group in two States (6%) and in one community (3%).

In four State (11%) and one community (3%) program surveyed, CWS staff have established goals aimed at meeting the needs of battered women and their families; for example, "to coordinate services with the Adult Protective Services program and to share case information" or "to consider the children of battered women as a priority with respect to service provision." Other CW respondents mentioned that they have informal program goals to serve battered women, but that these goals are not consistently applied.

Sixteen community CWS programs (48%) have intake and assessment procedures which include probes for spousal abuse. Respondents from these programs were asked to indicate the kinds of problems presented most often by battered women. Other forms of marital conflict, social isolation, emotional and alcohol abuse by the spouse, housing needs, legal protection, and child care were identified most frequently.

Many CWS respondents at the local program level noted that the purposes of the CWS program pertain to children; the primary purpose is to protect the well-being of the child. Any assistance provided to a battered woman is secondary to services provided to her as the mother of a child in need of help. The majority of CWS respondents indicated that when a woman/mother is identified as battered, she usually is referred to another service provider (e.g., a shelter program or an Adult Protective Services program).

In a few instances, CWS respondents identified innovative approaches which facilitate service provision to battered women. In one State, $90,000 of Title IV-B funds are used for the State's domestic violence program, which primarily serves families. The domestic violence program is administered through the Council on the Status of Women. In two other States, the use of a "family strategy" for all social service delivery provides an administrative rationale for CWS to deliver direct services to battered women and abusing spouses, providing there also are children involved. Specific services offered in these States include shelter, counseling, transportation, crisis intervention, and other forms of emergency assistance.

Since the predominant CWS activity undertaken on behalf of battered women at both the State (49%) and community (39%) program levels is coordination with other agencies, a closer look at coordination mechanisms is warranted. Most frequently, coordination is maintained through informal meetings with other agency staff. In some cases (23% of the States and 15% of the communities), a CWS program representative participates in a task force or committee concerned with the problem of spousal abuse. For example, in one State, the CWS program is working with a State-authorized task force to study family violence. A major product of this task force is a resource handbook for abused spouses.

In a few cases, specific agreements exist between the CWS program and other programs. For example, one CWS program has a unique agreement with the Medicaid program to investigate all medical referrals involving suspected child abuse and/or spouse abuse in families with children. Medicaid referrals are made each month to the CWS program based on an analysis of child and adult trauma cases receiving Medicaid assistance. Staff from another CWS program are involved with representatives from Title XX, LEAA, and Coalitions Against Domestic Violence to establish shelters throughout the State. In addition to these working relationships, at least three CWS programs have developed formalized referral arrangements with Adult Protective Services programs aimed at improving the delivery of services to victims of spouse abuse.

CWS staff from the 16 local programs surveyed (48%) which include probes for spousal abuse as part of their intake and assessment procedures were asked to identify the services to which battered women are referred. Staff from every program routinely refer battered women to health services. Nearly all of the staff make referrals to providers of mental health, legal, alcohol and drug abuse, housing, employment, and battered women's services. Less frequently, cases are referred to social service agencies. Once these referrals are made, CWS staff usually engage in information-sharing or have joint case planning meetings.

Some CWS program staff engage in advocacy efforts to help battered women. They have testified for passage of State legislation pertaining to domestic violence. Others have worked toward the development of a network of services available for abused spouses and their children. Some CWS staff encourage direct assistance to battered women through their program resources or through referral and follow-up activities. Advocacy activities are viewed by these staff as consistent with CWS policy because of the potential for emotional and physical harm to children during domestic disputes.

CWS staff were asked about any efforts in their State or community which might positively affect their program's ability to assist battered women. In a number of instances, legislative activities were identified. For example, several States have legislation pending to help protect battered women and provide needed services, such as counseling, housing, and transportation. This would expand the range of referral resources for battered women who are identified by CWS staff. In another State, a newly-passed law regarding restraining orders in cases of domestic assault is viewed as broadening the legal base for protection of both children and adults.

Barriers to Service Delivery

Most of the CWS respondents perceive eligibility limitations imposed by Federal and State legislation as the major barriers inhibiting their provision of services to battered women:

- State/Federal legislation earmarks funds for services to children only.
- The primary focus of CWS intervention must be on the welfare of the child.
- Legislative authority is lacking for CWS staff to serve adults.

According to respondents, CWS programs are mandated to serve children, and if a battered woman does not have children or if her children are not in need of CWS services, she cannot receive CWS services. Furthermore, in some instances, program staff may be unable to find any identifiable adverse impact on the child(ren) as a consequence of spouse abuse, thus preventing delivery of CWS services to the family.

A number of CWS staff expressed concern about having sufficient funds to fulfill their primary responsibilities for children, even less for abused adults. Similarly, CWS staff discussed the lack of community resources (e.g., shelters) which exacerbate the difficulties brought about by the lack of CWS program resources. Furthermore, lack of staff expertise or staff training on the needs of battered women are viewed as a major barrier to service provision.

Another barrier described by several State respondents relates to the organizational structure of the agency, which places the CWS program in one division or department and Adult Protective Services (APS) program in another. The separation of services for children and adults, with little or no coordination within the agency, limits the effectiveness of treatment strategies directed toward families, including those experiencing spousal abuse.

Respondents identified a major reason why it is not feasible for the CWS program to assume (additional) activities on behalf of battered women. This relates to the program mandate to focus on children whose basic needs are not being met. Fulfilling this mandate, especially in light of the magnitude of child abuse and neglect problems, utilizes all existing resources.

Program Recommendations to Enhance Service Delivery

Program respondents offered recommendations to enhance the capability of the CWS staff to serve abused spouses. Repeatedly, respondents at the State and local program levels mentioned the need for better coordination with other agencies that assist battered women. It was suggested that the incidence of domestic violence and the needs of battered women be documented to benefit the development and coordination of services.

Some respondents also suggested a change in the statutory language to allow CWS programs to serve battered women. Additionally, they noted the need for increased funding to support such an effort. Lastly, several forms of training and technical assistance were identified to increase the staff's ability to meet the needs of abused apouses and their families:

- Causes and dynamics of spousal abuse and its effect on children;
- Screening techniques to identify abuse in the absence of physical evidence;
- Skills and effective treatment strategies in working with domestic violence victims and abusers; and
- Information on ways to develop and make domestic violence program services accessible, including other providers' experiences.

SUMMARY

Overall, CWS program staff at both the State and community program levels are aware of the problem of spouse abuse and the needs of battered women and their families. The population served by CWS programs frequently presents cases of family violence; thus, familiarity with domestic violence issues and services to promote the welfare of the family are program strengths. However, in most States and communities, CWS staff report funding and staff limitations as seriously restricting their potential to expand services to battered women in their service population.

CHILD PROTECTIVE SERVICES
(As provided through the Social Services, Title XX, program)

AUTHORIZING LEGISLATION

Title XX, Social Security Act

FEDERAL AGENCY RESPONSIBLE

Office of Program Coordination and Review,
Office of the Assistant Secretary for Human Development Services,
Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

Although Child Protective Services (CPS) is not a DHHS program per se, this report singles out the CPS component of the Title XX program for separate analysis. Two primary reasons underlie this separate analysis. First, research studies on child abuse suggest a relationship between the presence of child abuse and other forms of family violence in the home, including spousal abuse. Second, many survey respondents from the Child Welfare Services program expressed the opinion that data gathered from CPS staff would broaden this study's findings.

Through the Social Services (Title XX) program, States are able to provide essential human services directed toward the goal of protection of children from abuse, neglect, and exploitation. States may offer these services to anyone who needs them, without regard to income or other eligibility criteria.

Each State designs its own Social Services plan and sets its own service priorities. Considerable variation exists among the States in terms of the breadth and types of services provided for children in need of protection. However, CPS investigation, counseling, day care for children, family planning, and transportation are among the services offered by most States.

ABSTRACT OF MAJOR PROGRAM FINDINGS

At the State program level, interviews were conducted with CPS administrators from 45 States and the District of Columbia.* At the local level, interviews were conducted with CPS administrators and direct services staff in 31 communities. These samples form the data base for the following discussions on study findings and are the basis for the percentages presented.

The major findings resulting from interviews with CPS staff are highlighted as follows:

*At the State program level, CPS administrators in five States did not participate in the State Survey.

- In nine percent of the States and in 16 percent of the communities, surveyed, CPS program staff have developed or adopted definitions of domestic violence.

- In 13 percent of the States and in one community (3%) surveyed, CPS programs focus on battered women; in four percent of the States on battered men; in 28 percent of the States and in 23 percent of the communities on the children of battered women; and in four percent of the States and seven percent of the communities on abusing spouses.

- CPS program staff in 17 percent of the States and in one community surveyed have developed goals which specifically address the needs of battered women.

- Direct services for battered women are provided by 20 percent of the States and 10 percent of the community CPS programs surveyed.

- In 39 percent of the States and 52 percent of the communities surveyed, CPS program staff reported that they coordinate their activities with other agencies on behalf of abused spouses and their families.

- In 14 States (30%) and in eight communities (26%) surveyed, there were CPS staff identified as advocates for battered women. In addition, CPS staff in 80 percent of the States and in 74 percent of the communities reported being aware of other advocacy efforts on behalf of abused spouses.

- Finally, in approximately two-thirds of the CPS programs surveyed at both the State (67%) and community (65%) levels, staff reported that CPS efforts to assist battered women are restricted by various barriers to service delivery.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

To build upon the major findings presented above, this section elaborates upon CPS staff efforts to assist battered women and the barriers to service delivery identified by CPS respondents. Recommendations made by respondents for improving the delivery of services to battered women also are presented.

Specific Program Efforts

In most States and communities surveyed, CPS staff reported that their efforts are focused on abused and neglected children; efforts directed toward abused spouses are secondary to this primary focus. Most respondents also reported that when victims of spouse abuse are identified by CPS staff, they are referred to other service providers (e.g., shelters or adult protective services programs) for direct help with the problem of spouse abuse. Where CPS staff are providing services directly to victims, there are abused or neglected children involved in the case.

Local CPS staff from 21 of the 31 communities surveyed (68%) reported that their intake procedures seek to identify victims of spouse abuse. These respondents were asked to identify the most frequent problems presented by battered women; they cited other types of marital difficulties, including emotional abuse by the spouse, and social isolation.

In 48 percent of the States and 52 percent of the communities surveyed, CPS staff are involved in some activities on behalf of battered women. Coordination with other service providers is the activity most frequently reported (39% of the States and 62% of the communities). A few programs at the State level have established formal linkages with other programs to help integrate service delivery to victims. One State is reorganizing its Adult Protective Services program with significant collaboration from the child welfare and child protective services divisions to develop a coordinated referral network among these service programs. In a second State, a formal agreement exists with the Medicaid program, whereby referrals of suspected spouse or child abuse cases from the Medicaid staff are investigated by CPS (and other) staff. A third State has developed a child abuse register and battered spouse register. Cross-referencing these registers permits CPS staff to follow-up on referrals and see that providers are providing the needed intervention.

Direct services for battered women were reported by State level CPS administrators in four States. These direct services include counseling through hotlines, crisis intervention, and family counseling. Some State level CPS programs also channel funds into shelter facilities targeted for families, children, and/or battered women. In these instances, the provision of direct services to battered women is considered an important part of the CPS strategy to assist the entire family.

CPS coordination activities at the community level are primarily directed toward establishing referral procedures among agencies. Apart from coordination, fewer community than State level program respondents reported carrying out activities for battered women. Three CPS programs, at the local level, however, have mandated activities on behalf of battered women, such as coordination of services and data collection.

In a few States and communities surveyed, CPS staff have worked toward passage of domestic violence legislation and also have worked to develop domestic violence service networks. In some communities, CPS staff have developed arrangements with the courts for alternative sentencing in spouse abuse cases. In other communities, staff have worked as volunteers in shelters and participated in workshops on domestic violence.

The majority of CPS State administrators and local staff surveyed are aware of advocacy group efforts outside of their programs. A number of State level CPS respondents reported that these efforts have had or could have an effect on their programs, since most of the advocacy efforts center around new legislation to protect and serve battered women. In addition, the provision of services (primarily shelters) and public awareness campaigns initiated by advocacy groups have extended resources to which CPS staff may refer the battered women they encounter.

Most CPS staff surveyed do not believe it is feasible to increase program activities directed toward abused spouses because of the lack of resources. However, among those CPS staff who believe it is feasible to increase activities, most identified expansion in the provision of direct services, staff training, and community education.

Barriers to Service Delivery

In 67 percent of the States and 65 percent of the communities surveyed, CPS program respondents identified barriers to serving abused spouses. Most of the respondents cited eligibility limitations imposed by State legislation and regulations as the major barriers.

Families identified as eligible for child protective services in State Title XX plans must have a child who is determined to be abused, neglected, or "at risk" of abuse or neglect. The child may be served without regard to any criteria other than the need for services. However, in some States, the adult victim in the family must be categorically or income eligible for Title XX in order to receive such support services as counseling, vocational education and transportation. These eligibility criteria exclude many battered women from receiving services. Even in those States where battered women are considered eligible for services, program resources (funding and properly trained staff) often are reported to be inadequate to meet the victims' needs.*

Program Recommendations to Enhance Service Delivery

CPS respondents at the State program level suggested that documentation of the incidence of domestic violence and the needs of abused spouses is necessary to encourage effective coordination of services. Local CPS respondents expressed the need for resolving jurisdictional problems involved in serving battered women. Several respondents suggested assigning an adult protective services worker to the CPS staff to promote a more comprehensive, integrated approach in serving the entire family.

To increase assistance to battered women, most State and community level CSP respondents agree that a State mandate, additional program resources, and training are necessary prerequisites. Respondents suggested that staff training be provided on the dynamics of spouse abuse, how to identify victims of spouse abuse, and treatment and intervention techniques for use in working with families who experience this problem.

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*To clarify these differences in eligibility among States, it is important to note that Federal eligibility requirements do not distinguish between child and adult victims of abuse in relation to access to protective services without regard to income. States, however, may establish eligibility criteria which are different for children, or may choose not to provide any services without regard to income.

SUMMARY

Child Protective Services staff are minimally involved in serving victims of spouse abuse. Generally, when CPS staff become involved with an abused spouse, the children are the primary recipients of services. A battered woman without children cannot be served directly by CPS staff, although she can be referred elsewhere for assistance.

Most respondents believe that the lack of a State mandate and limited funds and staff prevent CPS from expanding services to battered women. However, three factors influence the potential of the CPS programs to serve adult victims. One is the relationship between child abuse and spouse abuse. Evidence from research studies supports the view that both types of abuse frequently coexist within families. CPS staff repeatedly confirmed this view in unsolicited comments about the high incidence of adult abuse found in their child abuse caseloads. As a consequence of exposure to domestic violence in the families served by the program, CPS staff revealed a notably broader view than respondents from most other programs about the types of families and individuals who experience abuse. This factor, in combination with the first, helps explain the finding that a relatively high proportion of local CPS program staff (68%) probe for instances of battering between spouses in their intake and assessment procedures. The last factor relates to the service delivery approach taken and/or desired by several respondents; that is, a comprehensive service model directed toward the entire family. These factors contribute favorably to any future CPS program activities which may be directed toward abused spouses.

THE CHILD ABUSE AND NEGLECT PREVENTION AND TREATMENT PROGRAM

AUTHORIZING LEGISLATION

The Child Abuse Prevention and Treatment Act, as amended

FEDERAL AGENCY RESPONSIBLE

National Center for Child Abuse and Neglect (NCCAN),
Children's Bureau,
Administration for Children, Youth and Families,
Office of Human Development Services,
Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

The overall purpose of this program is to assist State, local, and volunteer agencies and organizations in strengthening their capacities to prevent, identify, and treat child abuse and neglect. Program funds are used to support projects which: (1) provide technical assistance to public and nonprofit private agencies and organizations; (2) provide for the development and establishment of multidisciplinary training programs; (3) assist States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs; (4) conduct research into causes, prevention, and treatment of child abuse and neglect; and (5) demonstrate new and/or innovative methods for identification, prevention, and treatment of child abuse and neglect.

Since a substantial portion of the funding for this program is directed toward demonstration, training, research, and technical assistance activities, funding for the provision of direct services to abused and neglected children and their families is limited. However, the direct services which are provided by demonstration projects cover a wide range of activities and approaches to the prevention, identification, and treatment of child abuse and neglect. For example, a project may offer direct services to children which include play therapy, group counseling, and day care, as well as direct services to parents which include parent support groups, parent effectiveness training, and assistance with concrete needs (e.g., food, clothing, housing). In brief, almost any human service may be integrated into a project's demonstration of ways to identify, prevent, or treat child abuse and neglect. There are a few currently funded demonstration projects which are focusing their services on abused children as well as on other forms of domestic violence within the children's families.

ABSTRACT OF MAJOR PROGRAM FINDINGS

This discussion of program findings is based on a Community Survey sample of six NCCAN funded demonstration projects in four States.* The types of programs included in this sample encompass child protective services, family resource centers, a parents' action network, and a residential facility for infants. The population eligible to receive services varies with the type of program. For example, staff from one project target services on infants, staff from another project target on "high-risk" families, and staff in a third project serve any family with problems related to child abuse or neglect. One project also has a residency requirement that limits its eligible population to the catchment area. Another project, which serves parents who have abused (or who are considered likely to abuse) their children, requires that the parents be self-referred. Staff from yet another project do not work with children who have severe physical or mental handicaps or with parents who are considered mentally retarded, drug abusers, or psychotic.

Findings from the survey of these six NCCAN projects reveal that one has a definition of domestic violence. This definition is based on the State child abuse law and, therefore, is not considered inclusive of spousal abuse. One NCCAN project administrator reported a program focus on, and the existence of goals directed toward, battered women. Respondents from another project reported that they are mandated to keep statistics on the incidence of spouse abuse within their client population.

In other areas of inquiry, NCCAN project respondents reported greater activity. In four projects, staff engage in the coordination of spouse abuse intervention activities with other service agencies. Staff in three of these projects also have received training related to spouse abuse. Staff from another project, which does not engage in coordination activities, have received similar training. In addition, in two of the projects surveyed, one or more staff members were identified as advocates for battered women; and, in all six programs, staff noted advocacy activities directed toward abused spouses occurring within their communities.

Staff from four of the NCCAN projects identified Federal, State or program regulations and directives which they believe restrict their ability to serve abused spouses. Staff from one of the projects (not identifying such restrictions) pointed out that, in their community, the "laws" do not make much difference, but that the availability of funding does make a difference.

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*This small sample reflects, in part, the low number of NCCAN funded programs across the country, as compared to other DHHS funded programs under study. In addition, a few NCCAN programs initially selected for the Community Survey were no longer receiving any NCCAN funding and/or were not providing any direct services. Consequently, these programs were eliminated from the sample. The final sample of six programs in four States is as comprehensive as possible.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

This section includes discussions on NCCAN program activities related to spouse abuse, barriers to service delivery, and recommendations to enhance service delivery.

Specific Program Efforts

Staff from one of the NCCAN projects surveyed have established the goal to obtain adequate preparation to deal with the problem of spouse abuse. Staff of this program reported that they explore the relationship between parents during the first interview to identify spouse abuse as well as child abuse. Staff of two other NCCAN projects also reported that they explore the relationship of parents at intake, but probe for spouse abuse only when it seems warranted; further, in one of these projects, staff probe for spouse abuse only during intake interviews with mothers, not when fathers are present. In general, across the six NCCAN projects surveyed, the identification of spouse abuse is most likely to occur through client self-disclosure. Once identified, NCCAN project staff normally refer the parents to other service providers for direct intervention.

Staff of one NCCAN project reported that of the 150 adults served during the past year, 25 were known battered women. Staff from two NCCAN projects also reported on the most frequent problems presented by the battered women within their client populations; these are emotional abuse by the spouse and other types of marital difficulties, child abuse by the spouse, social isolation and the need for legal protection.

Respondents from the project having data on 25 battered women gave information on the spouse abuse intervention strategies employed by staff. The two administrators and direct services staff of this project agreed that they use professional staff, therapeutic intervention with the abuser, and a traditional social services model. One administrator, however, indicated that staff provide ongoing treatment and attempt to reconcile the situation in the home, while the direct services staff and the other administrator indicated that staff provide crisis intervention and offer emergency shelter to the victim.

Several NCCAN project staff engage in consultation, coordination, and training activities on behalf of abused spouses. One administrator noted that the project serves as a domestic violence clearinghouse/information resource and provides technical assistance/consultation to other agencies. Respondents from four of the projects reported participation on domestic violence task forces/committees, and informal meetings, service and confidentiality agreements with other agencies, telephone contacts for referrals, and the sharing of program staff on activities related to the problem area.

As previously noted, in two projects, there were staff identified as advocates for battered women. For example, one staff member serves on the board of a local domestic violence program. With respect to the activities of local advocacy groups, several NCCAN respondents credited them with the opening of emergency shelters which, in turn, provide new referral sources.

Although not targeted on battered women, there are services presently available through NCCAN funded programs which may benefit battered women. For example, in addition to the above mentioned coordination and referral services, the surveyed NCCAN projects provide a range of services, including crisis intervention, counseling, parent education, peer support groups, advocacy, hotlines, transportation, and a "drop-in" child care center for the children of parents under stress. Further, one project operates a crisis play school for children under five, which is frequently used as a resource for the children of battered women who are staying at a local shelter.

In terms of future potential, four of the NCCAN administrators indicated that their programs could assume additional activities (such as technical assistance, consultation, community education, collection of statistics, and needs assessment) and take the lead in coordinating efforts on behalf of abused spouses. Direct services staff in two of these projects disagreed with their administrators and indicated that their current workloads do not permit expansion in these areas.

Barriers to Service Delivery

According to all NCCAN project respondents, the major barrier to meeting the needs of battered women is the program requirement that child abuse or neglect also be involved in the case. Another barrier, reported by one respondent, is the State's child abuse reporting law; that is, battered women whose children also are battered may be reluctant to seek help for fear of being reported.

According to respondents, yet another possible barrier to service provision for battered women is their own reluctance to seek help. Among the reasons cited for such reluctance among battered women are fear of the abuser, fear of having their children placed in foster family homes, lack of knowledge about resources, lack of confidence in professional services, social isolation, and lack of recognition of the problem.

In terms of assuming additional activities for victims of spouse abuse, respondents pointed out that NCCAN projects are funded specifically to focus on child abuse and neglect. Further, some respondents believe that not only would it be a duplication of effort for them to deal with abused spouses, but they already are struggling to provide adequate services for abused and neglected children. Respondents also pointed out that, in most cases, their communities are straining to provide services to battered women because of lack of money and/or community support. Therefore, even their referral sources may be cut back in the future.

Program Recommendations to Enhance Service Delivery

Respondents from two NCCAN projects provided suggestions for facilitating coordination efforts related to the problem of spouse abuse. They recommended that agency staff and resources be shared, that information be made available on services available through various agencies, and that groups of agency representatives be formed in their communities aimed at helping battered women.

Five program respondents recommended specific changes which could be initiated within NCCAN funded projects to improve services to abused spouses. Among these were staff training on domestic violence issues, changes in intake procedures (e.g., to increase probes for spouse abuse), and provision of more family therapy and crisis intervention services. One program respondent also suggested a revision of the NCCAN target population to include battered women. Respondents reported that the battered women with whom they have come in contact have viewed legal protection, transitional housing beyond emergency shelter, employment counseling and jobs, and incarceration of the abuser as primary service needs.

Finally, respondents from five of the projects offered recommendations for training they would like to receive related to the topic of spouse abuse. These include: training on the family dynamics of spousal abuse, including sensitivity training; information on the service needs of battered women; interviewing and counseling techniques; information on how to identify, understand, and help abusing spouses, especially on how to deal with the spouse after the victim enters a shelter; and training on domestic violence program resources available locally.

SUMMARY

In general, the NCCAN project staff surveyed are not providing direct services to abused spouses. When spouse abuse is identified, the response of the majority of the NCCAN project staff is to make referrals to other agencies which they consider more appropriate for dealing with the problem. NCCAN project staff, however, reported greater levels of activity in other areas (such as coordination of services for abused spouses), and offered suggestions which, if followed, would increase their potential to respond to the needs of victims in the future.

THE MEDICAID PROGRAM (TITLE XIX)

AUTHORIZING LEGISLATION

Title XIX, Social Security Act, as amended

FEDERAL AGENCY RESPONSIBLE

Health Care Financing Administration (HCFA),
Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

The primary purposes of the Medicaid program are: 1) to provide medical assistance on behalf of individuals whose income and resources are insufficient to meet the costs of necessary medical services, and 2) to furnish rehabilitation and other services to help individuals attain or retain capability for independence or self-care. The Medicaid program is not mandatory; for example, Arizona does not have a Medicaid program. Program eligibility criteria limit assistance and services to needy persons over age 65, the blind, the disabled (SSI recipients), members of AFDC families, the medically needy (persons who can independently meet their daily living expenses but are unable to pay for their medical care), and, in some States, persons under age 21 who are "wards of the State."

The specific program services provided (i.e., the medical care which is paid by Medicaid) vary from State to State, except for those general service areas mandated by Federal regulations (e.g., in-patient and out-patient hospital services, physicians' services, and family planning services.)

ABSTRACT OF MAJOR PROGRAM FINDINGS

The findings presented herein are based on interviews with State level Medicaid program administrators and with local staff who have responsibility for processing applications to determine eligibility for Medicaid assistance. In the State Survey, 48 administrators participated in the study effort.* On the local level, staff in 36 communities, representing 14 of the 15 States selected for the Community Survey, participated in the study.

- In one community (3%) surveyed, Medicaid program staff have developed a definition of domestic violence.
- The Medicaid program in one State (2%) focuses on battered women; none of the programs surveyed focus on battered men, children of battered women or abusing spouses.

*As noted, Arizona does not have a Medicaid program, and CSR was unable to arrange interviews with program representatives from two other States.

- Medicaid program staff in two communities (6%) surveyed, have established goals and objectives pertaining to the needs of battered women.
- Medicaid program staff in one State (2%) and in one community (3%) surveyed provide direct services for battered women. In the community, the Medicaid program has mandated responsibilities to assist battered women.
- In eight percent of the States and in 17 percent of the communities surveyed, Medicaid program staff have worked with other agencies to coordinate services for victims of domestic violence.
- Medicaid program staff in six percent of the States and 19 percent of the communities surveyed have received training related to the problem of domestic violence.
- Medicaid program respondents in four percent of the States and 22 percent of the communities surveyed identified themselves or other Medicaid staff as being advocates for domestic violence victims.
- Medicaid program respondents in 54 percent of the States and 78 percent of the communities surveyed identified barriers to service provision for abused spouses.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

Federal legislation authorizing the Medicaid program does not permit targeting on any specific group to the exclusion of others; the eligibility criteria are fairly straightforward and limit services generally to the poor and/or the disabled population. Since intact families usually are not covered for health care under Medicaid, women who are abused by their spouses represent a small proportion of Medicaid eligibles.

Most Medicaid staff reported that victims of spouse abuse who meet the program's eligibility requirements receive the same services as other Medicaid recipients. There were few examples cited by respondents of any special program efforts to identify or assist victims. Therefore, the following sections describe the Medicaid program's current limited involvement with the problem of domestic violence. Barriers to service provision, as reported by staff at the State and community levels, also are discussed. Finally, program staff recommendations for changes to enhance the capability of the Medicaid program to assist abused spouses and their families are presented.

Specific Program Efforts

Overall, any Medicaid services provided to a battered woman are provided on the basis that she "belongs" to the general eligible population. Most Medicaid program respondents, at the State and community levels, responded that

staff have not developed definitions of domestic violence, nor have they established goals aimed at assisting abused spouses. However, a few program staff participated in some activities on behalf of victims such as direct services, community education on the problem, and coordination of State and local resources.

Generally respondents at the local level indicated that if they identify a battered woman, they refer her to Social Services staff for help. However, it is unlikely that an applicant would be identified as a victim of domestic violence, since the application process does not usually include a social assessment.

As mentioned above, some Medicaid program staff have worked with staff from other agencies to coordinate services for abused spouses. In eight percent of the States and in 17 percent of the communities surveyed, Medicaid program staff have engaged in such coordination efforts. One example of coordination occurred subsequent to a State's passage of a domestic violence bill. State Medicaid and Title XX staff established an effective referral system, and this coordination has continued at the local level. In addition, there are semi-annual meetings for Medicaid and Title XX staff which include training and technical assistance related to the problem of domestic violence.

In one State Medicaid program surveyed, staff have initiated special efforts on behalf of battered women. The Quality Assurance Division of this Medicaid program has developed a "memo of understanding" with the Professional Standards Review Organization (PSRO). This results in a review of all adult and child trauma services on a monthly basis, using information stored in a computer. Professional analysts determine whether domestic violence is a possible cause of the need for trauma services. If domestic violence is suspected, the case is referred to the Division of Children, Youth, and Families (CYF). A CYF caseworker is assigned to follow-up on the case.

Staff from two communities in other States have initiated special efforts to assist battered women which also illustrate the intervention potential of the Medicaid program. In one community, the Medicaid program guidelines contain a "speed-up" clause requiring virtually immediate processing of applications by victims of domestic violence. In another community, program staff noted the Early Periodic Screening Diagnosis Treatment (EPSDT) program as a mechanism for identifying battered women. The EPSDT program, which is targeted on children, requires staff to inform clients of the availability of Medicaid for all psychological and physical help, ages 0 to 21 years. Respondents believed that this procedure may identify, along with battered children, their battered mothers. Thus, the mothers could also receive aid and referral assistance.

Medicaid administrators in two States (4%) and staff in eight communities (22%) stated that they, or other Medicaid staff, take an advocacy role in encouraging help for victims. Medicaid staff in 56 percent of the State and 61 percent of the community programs surveyed also are aware of other advocates working on behalf of battered women.

Program respondents were queried as to the potential of the Medicaid program to assist abused spouses. Respondents in most States and communities surveyed reported that it is not feasible for Medicaid staff to assume any (additional) activities for this population. The reasons why most respondents do not believe it is feasible or appropriate are discussed below.

Barriers to Service Delivery

Barriers to Medicaid assistance for abused spouses were identified by program staff in 54 percent of the States and 78 percent of the communities surveyed.

Before discussing specific barriers, three underlying issues require review. First, most respondents indicated that it is not within the purview of the Medicaid program's legislative mandate to direct attention on the needs of battered women. Thus, even though some barriers cited relate to the program mandate, respondents do not necessarily believe that the mandate should be changed. Second, some of the barriers cited are specific to certain States or communities. This is especially the case with program eligibilty requirements and vendor payment policies. Finally, some barriers identified are based on perceptions of restricting factors rather than on facts.

Many of the barriers noted relate to the authorizing Federal legislation. Several respondents stated that Medicaid is prohibited from targeting services for special populations based on medical diagnoses and they consider physical battering a medical diagnosis. The legislated program emphasis also was identified as limiting the extent to which victims can be served. For example, several program staff commented that the Medicaid program is concerned primarily with medical needs, and that the problem of spouse abuse is related more to social needs. Thus, these staff concluded that social service agencies should be the primary service providers for abused spouses.

Federal and State Medicaid legislation also result in other types of barriers limiting service delivery. A major barrier cited was eligibility criteria, especially income restrictions. In general, these eligibility criteria are Federally imposed; however, State regulations also affect eligibility. One effect of the eligibility criteria is that only victims who are poor are eligible for Medicaid services. Further, since AFDC recipients are eligible for Medicaid services, AFDC eligibility criteria relate directly to Medicaid eligibility. A respondent in one State mentioned that the abusing spouse's income is considered in determining the battered woman's eligibility; thus, a battered woman may not be eligible for AFDC or Medicaid unless she is legally separated or divorced from her spouse.

Barriers specific to State legislation also were identified by respondents. For example, State legislation limits the types of service providers that can be reimbursed. According to program staff in some States, psychologists and clinical social workers cannot be reimbursed for counseling services unless their services are provided through public or nonprofit community agencies. However, in other States, Medicaid pays for private counseling services provided by psychologists and/or clinical social workers.

Another major barrier, cited by respondents, is insufficient program resources to provide additional or special services to abused spouses. Also, there is a lack of medical social workers in the Medicaid program, limiting the program's capacity to provide services effectively. This lack of program resources tends to limit the extent to which the Medicaid program staff can coordinate with other programs to serve victims. Coordination among programs, according to staff, is also difficult to accomplish because of the issue of client confidentiality. Service providers are reluctant to refer abused spouses, without their expressed consent, for fear of violating client confidentiality.

Medicaid respondents also reported their concern about the lack of shelters and other community services for battered women and their families. They cited lack of community awareness of the problem and lack of community concern for battered women as contributing to these insufficient local resources.

In summary, several respondents indicated that Social Services (Title XX) is the appropriate service delivery mechanism for abused spouses, and that the Medicaid program would have to be rewritten to aid this population. Generally, respondents believe that no special assistance for victims can be provided by the Medicaid program without a specific mandate to do so. Although the potential for the program to serve abused spouses is considered limited by respondents, some changes were recommended to increase the potential.

Program Recommendations to Enhance Service Delivery

State and local program staff offered some recommendations to enhance the Medicaid program's response to the needs of abused spouses and their families. However, less than one-half of the State level respondents offered suggestions compared to almost all of the local staff. The recommendations should be viewed within the context of what most respondents believe is necessary to help victims, if the Medicaid program were to assume additional responsibility in this area.

Most of the changes identified relate to Federal statutes, Federal and State eligibility requirements, and the need for increased funding. For example, many respondents noted the need for a mandate authorizing Medicaid assistance to battered women as a focal group. They also noted that State regulations regarding eligibility criteria would require revision for more victims to be considered eligible for Medicaid assistance. If such changes took place, respondents believe that additional program resources would be required as well.

Within the scope of current program resources, respondents suggested training for staff on the problem of domestic violence and the implementation of intake processes to include screening for spousal abuse. Respondents also had suggestions for improving the coordination of community services for victims and their families. Suggestions included training law enforcement personnel to coordinate with social service agencies, establishing a central agency to assume primary service responsibility for victims, and further public education on the problem of spouse abuse.

SUMMARY

Generally, Medicaid program staff are not involved in special activities on behalf of battered women. Most respondents do not believe it is feasible or appropriate for the Medicaid program to provide special assistance to battered women. However, because States are given considerable flexibility in the administration of Medicaid, some program staff have initiated steps to be more responsive to the needs of victims. There appears to be further potential within the parameters of the existing program mandate for staff to outreach eligible battered women and their families through the EPSDT program and to speed up victims' applications--as long as services provided thereby (e.g., physicians' services) are generally available to other beneficiaries of the program. Staff also expressed their interest in receiving training on the problem and in furthering their coordination activities with other programs.

THE COMMUNITY HEALTH CENTER PROGRAM

AUTHORIZING LEGISLATION

Public Health Services Act, Title III, Section 330, as amended

FEDERAL AGENCY RESPONSIBLE

Bureau of Community Health Service, Health Services Administration, Public Health Services, Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

This program supports the development and operation of Community Health Centers (CHC) which provide primary, supplemental, and environmental health services to medically underserved populations. Three types of Federal grants are available for funding CHCs: grants for planning and developing CHCs, grants for CHC operation, and grants for the development of prepaid health plans. Medically underserved populations eligible for CHC services may be defined geographically (e.g., a specific rural area) or on the basis of specific subpopulations (e.g., minority or disadvantaged groups).

The provision of primary health services to a medically underserved population is the program's chief purpose. Primary health services are mandatory for all CHCs and include: the services of physicians and physician extenders (e.g., nurses, paramedics) for preventive, acute, and chronic primary medical care; diagnostic services (e.g., laboratory tests); preventive health services (e.g., screening examinations, family planning); emergency medical services; and pharmaceutical services. Supplemental and environmental health services are optional and range from hospital, mental health, and health education services to services directed toward the alleviation of unhealthful conditions.

Although a State must have on file with DHHS an approved State health plan before CHC grants can be approved, grants are made directly to and administered by local CHCs. Local CHCs are run by community boards, not by any governmental body, and usually operate on a sliding scale fee basis. Many CHCs are located in rural areas and many have small staffs.

ABSTRACT OF MAJOR PROGRAM FINDINGS

Because the Community Health Center program operates at the community level and does not have a corresponding administration at the State level, all interviews were conducted with local CHC program administrators and direct services staff. The findings presented in this and subsequent sections are based on a sample of 25 CHC programs selected randomly across 15 States.

In general, the findings indicate that the Community Health Center program is not directly involved in meeting the needs of battered women and their families:

- Three CHC programs, representing 12 percent of the communities surveyed, have formulated or adopted definitions of domestic violence.
- In 96 percent of the communities surveyed, CHC program staff reported no special program emphasis on battered women, their children, battered men or abusing spouses. In one community, the CHC program staff reported they focus on battered women seeking CHC services, but not on any other domestic violence subpopulations.
- In eight percent of the communities surveyed, CHC program staff reported goals or objectives related specifically to the needs of battered women.
- In 16 percent of the communities surveyed, CHC program staff reported they provide direct services for battered women; one CHC program is mandated to do so.
- In 40 percent of the communities surveyed, CHC program staff are involved in coordination activities related to the problem of domestic violence.
- In 76 percent of the communities surveyed, CHC staff are aware of the efforts of battered women's advocacy groups. In addition, 32 percent of the respondents view themselves or other CHC staff as taking on advocacy roles to benefit victims.
- CHC staff in 32 percent of the communities surveyed have received training or technical assistance related to the problem of domestic violence; 68 percent reported that such training has not been provided to program staff.
- In 24 percent of the communities surveyed, CHC program staff identified barriers at the Federal/State level which restrict the CHC program from serving battered women.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

This discussion is organized into three areas, each of which provides an indicator of CHC program potential. Examples of CHC program staff efforts related to the problem of spouse abuse are presented to illustrate the current "state-of-the-art." Barriers which inhibit CHC staff from meeting the needs of victims are discussed. And, third, CHC staff recommendations for improving the service delivery for battered women and their families are presented.

Specific Program Efforts

Generally, battered women within medically underserved populations are eligible to receive CHC services. In most CHC programs, however, staff do not take any special steps to identify them. When battered women are identified, they usually are referred by CHC staff to other community agencies for direct assistance.

Staff from two CHC programs indicated program goals specifically related to the needs of victims. These goals actually pertain to "providing accessible health care" to all residents living in their programs' catchment areas. Supplementary comments, however, reflect staff knowledge of and sensitivity to the needs of battered women; thus, they interpret the general program goals as specific to the needs of battered women.

CHC program staff in 52 percent of the communities surveyed (13 programs) are aware of abused apouses in their client populations, but no statistics are collected by them on the actual numbers of battered women served. These CHC staff were asked to identify the most frequent types of problems presented by battered women. They identified other types of marital problems, unemployment, alcohol and emotional abuse by the spouse, child care and child behavioral problems, and social isolation. Medical problems were identified by less than one-half of the CHC respondents.

In response to the problems presented by battered women, CHC program staff in 28 percent of the communities surveyed reported they are involved in domestic violence consultation, technical assistance, needs assessment, and staff training activities. In 16 percent of the communities, or four CHC programs surveyed, staff respond by providing direct services to victims.

When battered women are identified, the 13 above-mentioned programs rely heavily on referral sources for the provision of services. Battered women are frequently referred to: other health service providers (usually hospitals); social services and public welfare agencies; mental health agencies; alcohol and drug treatment programs; the legal system, including the courts; and special programs for battered women (where available).

In these 13 programs, staff reported on their two most frequent activities following referral. Eight programs routinely share information about the battered woman with the referral source(s); seven programs do follow-up with the battered woman; three programs hold joint case planning meetings; and three programs monitor the referral agency's activities. In four of the programs, staff reported that they routinely transfer or close the case upon referral.

In 48 percent of the communities surveyed, CHC program staffs are not identifying battered women in their client populations nor are battered women being referred by them to other service providers. Several of the CHC program staff reported that identification and referral of battered women and/or provision of direct services to this group are beyond the scope of their programs. On the other hand, several other CHC program respondents reported that when spouse abuse is suspected, staff probe for verification and offer either direct or referral assistance. One CHC has a referral specialist on staff who seeks to identify and refer victims to needed services.

In 40 percent of the communities surveyed, CHC staff are involved in coordination activities for victims and their families. In 16 percent of these communities, the CHC program has a service agreement with other services providers; in 12 percent of the communities, CHC program staff participate on domestic violence task forces; and in another 12 percent, CHC program

staff have informal meetings with other service providers. For example, in one community the CHC program is a member of the Spouse Abuse Network. This network includes representatives from the CHC program, the Community Mental Health Center, and the Department of Social Services (DSS). Meetings focus on the coordination of services to battered women and on the development of an emergency shelter with DSS assuming the lead role.

In eight programs, representing 32 percent of the communities surveyed, CHC staff assume an advocacy role to help abused spouses. For example, the staff has conducted in-service training on spousal abuse, testified before State legislatures in favor of legislation to help battered women, written proposals toward the prevention of domestic violence, supported the establishment of shelter programs, and initiated direct counseling services for battered women.

In 76 percent of the communities surveyed, CHC staff is aware of and has reported on the accomplishments of various women's advocacy groups. Program respondents credit these groups with the provision of shelter and support services, community education, crisis intervention, telephone counseling, and peer support. These advocacy groups currently play a significant service delivery role, according to those CHC program staff who are active in the referral of spouse abuse victims.

CHC staff in 50 percent of the communities surveyed believe it feasible for the CHC program to assume additional activities on behalf of victims and their families. Activities most often suggested are community education, staff training, outreach, technical assistance, and consultation.

Barriers to Service Delivery

A variety of barriers to assisting victims were identified by CHC program respondents. Barriers cited most often include the lack of a Federal mandate establishing abused spouses and their families as a CHC target population; the lack of adequate and stable Federal funding for CHC staff and services in general; and CHC adherance to the Privacy Act (e.g., confidential information about a patient cannot be shared by CHC staff unless the patient gives consent).

Other barriers reportedly affecting CHC service delivery in some communities include: lack of CHC staff knowledge and expertise related to the problem of domestic violence; the lack of available CHC services after normal working hours; the seemingly small number of battered women seeking services from CHCs; and a CHC program focus on other populations (e.g., pregnant adolescents, individuals seeking family planning services).

Program Recommendations to Enhance Service Delivery

CHC respondents offered a variety of suggestions to enhance the program's response to victims and their families. Increases in CHC program funding and staff are the most frequently cited recommendations, followed by a need for staff training on a variety of topics related to the problem of domestic violence. Specific suggestions for CHC training include:

- Activities to increase staff awareness of and sensitivity to the problem of spouse abuse.

- Workshops aimed at improving skills on the identification of spouse abuse through physical indicators as well as through other means (e.g., communication and interviewing).

- Discussions on alternative CHC strategies for service provision to battered women and their families.

- Information on referral sources available locally and in neighboring communities.

- Seminars on the psychological aspects of spouse abuse with regard to both the victim and the abuser, and accompanying counseling techniques.

- Information on the legal rights of battered women.

Other recommendations cited by respondents for enhancing the CHC program's responsiveness are:

- The establishment of CHC program goals and objectives directed toward meeting the needs of battered women and their families.

- The development of (additional) CHC linkages with other local service providers.

- The establishment of spouse abuse screening procedures at the point of CHC intake.

- CHC provision of community education on the problem of spouse abuse as well as provision of group counseling and follow-up services for battered women.

SUMMARY

Community Health Centers offer a variety of services which are generally available to medically underserved individuals living within their respective catchment areas. The study findings indicate that one-half of the CHC respondents surveyed are aware of spouse abuse victims within their client populations. Of these, four CHCs have staff who are involved in providing direct services to victims; a larger number of CHC staff is involved in some referral and coordination activities on behalf of battered women.

In general, the potential of the CHC program to assist abused spouses is in marked dispute among program respondents. Approximately one-half of the respondents do not consider it feasible or appropriate for their programs to become involved in the problem of domestic violence. The other half support CHC's expansion into this problem area. Expansion appears to depend upon an

increase in CHC staff awareness of victims within their service populations as well as clarification of the potential role of staff in direct service, referral, and/or coordination activities. The potential for involvement also appears greatest in those CHCs which provide supplemental services.

THE SOCIAL SERVICES PROGRAM

AUTHORIZING LEGISLATION

Title XX, Social Security Act

FEDERAL AGENCY RESPONSIBLE

Office of Program Coordination and Review,
Office of the Assistant Secretary for Human Development Services,
Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

The Social Services (Title XX) program provides funding to States for human services. Each State is required to furnish at least one service directed to each of the following five goals: (1) financial self-support; (2) personal self-care; (3) protection of children and vulnerable adults from abuse, neglect, and exploitation, as well as strengthening family life; (4) avoidance of inappropriate institutionalization by providing services in the local community, often in people's own homes; and (5) appropriate institutional placement and services when it is in a person's best interests.

Persons eligible for Title XX services are current recipients of Aid to Families with Dependent Children (AFDC), recipients of Supplemental Security Income (SSI), and persons whose income does not exceed 115 percent of the State's median income for a family of four (adjusted for family size). States may offer information and referral and family planning services, as well as services directed toward the goal of protecting children and vulnerable adults as needed, without regard to income or other eligibility limitations. State eligibility requirements differ for services, groups of people, and/or parts of the State. For example, in one State, Title XX services are provided to abused spouses on the basis of group eligibility.

Each State designs its own social services plan and sets its own social services priorities. There is considerable variation among the States in terms of the types of services provided as well as their extensiveness. However, counseling, day care for children, education and training, family planning, homemaker services, protective services for children, and transportation are among the services offered by most States.

ABSTRACT OF MAJOR PROGRAM FINDINGS

The data presented in this abstract are based on interviews conducted with State level Title XX program administrators in 50 States, with State level administrators of five Adult Protective Services (APS) programs, and

with local social services staff in 45 communities.* Due to the very limited number of APS programs surveyed, information on APS is presented in subsequent sections only where unique activities are noted or where the data from APS differs markedly from the Title XX program.

The numbers 50, 45, and 5 are the bases for the respective data from Title XX programs at the State level, local Social Services programs, and the State APS programs. Study findings are as follows:

- In 22 percent of the States and 16 percent of the communities surveyed, program staff have established or adopted definitions of domestic violence.

- In 60 percent of the States and 36 percent of the communities surveyed, respondents reported some focus on battered women, battered men, abusing spouses, and/or children of battered women.

- In 20 percent of the States and in 16 percent of the communities surveyed, Title XX plans include goals pertaining to the needs of battered women.

- In 22 percent of the States, the Title XX program has a State mandate to serve abused spouses. Approximately 16 percent of the local social services programs surveyed are mandated by the State to provide direct services to this population; a smaller proportion also are mandated to undertake various other activities in the interest of battered women.

- On the State level, in 36 percent of the Title XX programs surveyed, staff engage in some activities for battered women, although not mandated to do so. Local social services staff also are engaged in a variety of nonmandated activities for battered women, the most common being staff training (13%) and community education (11%).

- In 56 percent of the State Title XX programs and 29 percent of the local social services programs surveyed, some coordination activities are directed on the problem of domestic violence.

- Training to enable program staff to better understand the needs of abused spouses and their families has been provided in 34 percent of the States and in 44 percent of the communities surveyed.

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*The five APS programs surveyed are distinct State legislated and authorized programs; they are funded primarily by Title XX, Title II and State monies. The APS programs are included in this report because of their reliance on services funded through the Title XX program.

- In 46 percent of the States and 36 percent of the communities surveyed, one or more program staff have functioned as advocates for victims of domestic violence.

- In 80 percent of the States and 67 percent of the communities surveyed, program staff are aware of grassroots activities focused on services for domestic violence victims.

- Title XX respondents in 72 percent of the States and 53 percent of the communities surveyed perceive Federal, State or program regulations as restricting the provision of services for abused spouses.

The following summarizes quantitative data from the five State APS programs surveyed:

- Two of the five APS programs surveyed have definitions of domestic violence.

- In three of the five APS programs surveyed, staff are focusing to some extent on battered women, battered men, abusing spouses, and/or children of battered women.

- Two of the five APS programs have State mandates to serve battered women.

- Staff from two other APS programs have conducted some nonmandated activities to help battered women.

- Staff from four of the five APS programs surveyed are involved in coordination activities related to the problem of domestic violence.

- Two of the five APS programs have provided staff training on domestic violence.

- Respondents from two of the five programs view themselves as advocates for battered women.

- Respondents from all five APS programs are aware of external advocacy efforts focused on services for domestic violence victims.

- In four of the five APS programs, respondents identified Federal or State barriers to serving battered women.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

In assessing the potential of Title XX programs to assist battered women and their families, the following areas are considered: specific program activities related to domestic violence and the scope of those activities,

barriers to service delivery identified by program respondents, and recommendations from program respondents for enhancing the delivery of services to battered women.

Specific Program Efforts

As previously noted, administrators of 30 State Title XX programs (60%) reported a program focus on battered women, battered men, children of battered women, and/or abusing spouses. Of these 30 programs, 57 percent focus on battered women, 43 percent on children of battered women, 40 percent on battered men, and 27 percent on abusing spouses.

At the State level, 11 (22%) of the Title XX programs surveyed have established or adopted definitions of domestic violence and ten (20%) have goals pertaining to the needs of abused spouses. Two of the APS programs surveyed (40%) have established definitions of domestic violence but none have goals related to assisting battered women.

Some of the State level definitions of domestic violence specifically reference spouse abuse while others refer more generally to populations in need of all adult protective services due to "abuse, neglect, or exploitation." Only two respondents on the State level, one from a Title XX program and one from an APS program, indicated that the staff's ability to serve battered women is restricted due to the definition of domestic violence. In these instances, the definitions specified the characteristics of victims (e.g., marital status) and the types of abuse.

With regard to local social services programs, staff from 16 (35%) of the communities surveyed reported a focus on battered women, battered men, children of battered women, or abusing spouses. Of these 16 programs, 88 percent focus on the children of battered women, 71 percent on battered women, 35 percent on abusing spouses, and 29 percent on battered men.

Respondents from seven (16%) local social services programs reported a definition of domestic violence, and in four of these programs, respondents believe the definition limits staff ability to serve battered women. Seven local social services programs (16%) have goals aimed at assisting battered women.

In 11 States, Title XX programs (22%) have a State mandate to assume some responsibility for battered women, and in 18 States (36%) Title XX staff are engaged in activities without a mandate. The most common activities include: program funding (16% mandated, 16% nonmandated), program planning (14% mandated, 12% nonmandated), program monitoring (16% mandated, 12% nonmandated), technical assistance and consultation (14% mandated, 10% nonmandated), and provision of direct services (14% mandated, 24% nonmandated).

Direct services provided to battered women and their families, as reported State Title XX program administrators, include crisis intervention services, such as emergency shelter, crisis hotlines, crisis counseling, emergency 24 hour care, respite care, and emergency health care, and ongoing services such as mental health services, legal aid, transportation, advocacy,

outreach, day care, foster family care, health care, and court accompaniment. It is assumed that these services are provided within the limitations in the Title XX law and regulations. Where battered women do not meet Title XX funding criteria, they are referred to other service providers or provided services through non-Title XX funds.

In at least one State, the Title XX program has a State mandate to provide services to both the victim and the abusing spouse. One Title XX program has a mandate to serve "vulnerable adults," but it has not yet been determined whether to include battered women in this category. Another program fulfills its mandate by providing generic adult protective services rather than services targeted on abused spouses.

In several States, services for domestic violence victims are included in the Comprehensive Annual State Plan (CASP). One State's CASP has an optional category of services to victims of domestic violence. To date, 25 counties in this State offer services under this option. In another State, Title XX funds are used in an Emergency Family Service Program, through which six shelters receive funding. In yet another State, the State Coalition Against Domestic Violence uses Title XX funds to subcontract for services to battered women and their children with the goal "to prevent or remedy abuse to adults" in programs with three services: 1) emergency shelter, 2) ongoing services, and 3) emer- gency health care. Another State purchases room and board for battered women for up to 21 days. This State's Title XX program has funded a Statewide domestic violence incidence survey, has provided staff training on domestic violence, and has engaged in public awareness activities.

Several other States also provide limited Title XX funds to shelter programs providing counseling and support services to those victims eligible for Title XX services. Some program staff interpret the Federal program goal to protect vulnerable adults as applicable to the shelter needs of battered women. Additionally, in at least two States, Title XX funds are used to provide battered women with care in residential facilities that also house alcoholic and/or mentally ill women.*

None of the State Title XX program administrators were able to provide exact data on the number of battered women served. However, administrators provided data on the proportion of the total Title XX budget which is spent on domestic violence-related services. For example, one State, where the total

*At the time the State Survey was conducted, Federal regulations governing Title XX did not allow reimbursement for emergency shelter for adults, unless "room and board" was "integral but subordinate" to a service described in the State's CASP. Subsequently, P.L. 96-272 "Adoption Assistance and Child Welfare Act of 1980" was enacted which allows for Federal reimbursement of emergency shelters for adults as an optional service.

Title XX budget is $88 million, allocates $1.2 million for services to victims of domestic violence. Another State's total Title XX budget is $221 million, with $1.9 million allocated for victims' services.

Generally, the five APS programs surveyed are less involved in activities for abused spouses, even though two have mandates to provide services to battered women, and two others are involved in nonmandated activities. One APS program has a staff member in each county assigned to work exclusively with domestic violence victims. Examples of other APS program activities targeted on battered women are: 1) staff trained as paralegals to act in behalf of battered women in court actions and 2) the establishment of a registry of spouse abuse cases, to which law enforcement personnel are required to report. Within 24 hours after receipt of the report, an APS team visits the victims. For the purpose of completing the APS investigation, access to the family's medical records is authorized.

On the local level, respondents from 18 of the 45 social services programs surveyed (40%) indicated that staff engage in activities to help battered women. Activities most frequently performed by social services staff include: collection of statistics (11% mandated, 7% nonmandated), staff training (11% mandated, 13% nonmandated), community education (2% mandated, 11% nonmandated), and provision of direct services (16% mandated, 9% nonmandated). Direct services which are available to battered women and their families through some local programs include: crisis intervention; emergency shelter; emergency 24 hour care; crisis counseling; investigations of reported abuse; psychological testing and evaluation; individual, family, and group counseling; foster family care and day care; medical services; job counseling; advocacy; and volunteer services.

Generally, local social services programs do not provide services to a battered womam without regard to her income. Rather, services are provided to a battered woman if she meets other eligibility criteria. Respondents, however, noted that battered women are usually referred to other service providers when they are not eligible for Title XX or when Title XX services do not meet some of their needs. Many respondents emphasized that program staff take an active role in arranging for services for battered women, for example, by setting up appointments with other service providers.

Two communities surveyed in one State have social services staff who conduct investigations regarding domestic violence and provide services to battered women. These activities are required by State law; the Department of Social Services is vested with the responsibility. In one of these communities, there is a specialized adult protective services worker who conducts the investigations and provides most needed services directly or by referral. In the other community, there is not a specialized worker, and none of the staff perceive themselves as trained to work with battered women. Thus, once the investigation is completed, the staff believe that there is little they can do other than some supportive counseling.

Administrative action facilitating service provision to battered women was reported in one of the communities surveyed. The local social services administrator has determined that protective services should be available to

children and adults in need, including battered women. Thus, in this program, the issue of domestic violence is "aggressively addressed," and comprehensive services for victims are available for six to ten weeks.

In local programs which provide direct services to battered women and their families, staff were asked about the service strategies they use. Of these 11 programs, 91 percent use professional staff and 9 percent use lay staff. Eight programs (73%) are oriented toward crisis intervention rather than ongoing services. Six of the 11 programs (54%) focus on reconciliation of the battered woman with the abuser, while four programs (36%) focus on provision of emergency shelter, and one program respondent did not know which strategy was most applicable. With regard to therapeutic versus court intervention, respondents from six programs advocate the former, four advocate the latter, and one did not know. Finally, 73 percent of the 11 programs use a traditional social service model and 27 percent use a self-help model.

Twenty-six of the 45 local programs participating in the Community Survey have intake procedures which incorporate some methods for identifying battered women. Respondents from these 26 programs were asked to identify the kinds of problems most frequently presented by battered women. The most common include other types of marital problems (92% of the 26 programs), unemployment (40%), emotional abuse by the spouse (62%), housing needs (46%), and legal protection (46%).

Very few local staff were able to provide details on the number of victims served or the proportion of the Title XX budget spent on services to victims. One program served 606 battered women and 814 children of battered women last year and allocated approximately two percent of a total budget of $330,000 for services to victims. Another program respondent estimated that 380 battered women were served during the past year out of a client population of 12,000. Still another respondent estimated 30 to 40 battered women served out of a total client population of approximately 1800 per year.

A number of Title XX program respondents, both on the State and community level, indicated that it is feasible for their programs to assume activities (or additional activities) in the interest of battered women. Most frequently, State and community program staff suggested they have the potential to provide direct services to battered women. Other activities frequently considered feasible on both levels are needs assessment, staff training, and community education, plus, at the local level only, the establishment of a clearinghouse. Many respondents qualified their answers, however, saying that these types of activities are possible only if funding levels increase.

Coordination activities by program staff for battered women appear to be more extensive on the State than on the community level. Fifty-six percent (56%) of the State Title XX staff and staff from four State APS programs (80%) participate in coordination activities for this population. By comparison, 29 percent of the local programs have staff who coordinate with other agencies to serve battered women.

In analyzing coordination activities in more detail, a variety of activities were described by respondents. At the State level, one Title XX

program is participating in a Statewide effort to coordinate services for battered women. In another State, staff from the adult protective services division and child and family services division have worked together to identify and develop a list of resources for battered women. In yet another State, a confidentiality agreement was reached with a shelter, whereby codes (rather than names) are used by the shelter to identify clients for Title XX reimbursement purposes. Several respondents also mentioned active involvement with other groups working toward passage of legislation favorable to domestic violence victims.

Some Title XX program staff coordinate their activities with a variety of other programs. One State's Title XX program has established formal funding procedures with the Division of Women and the State Law Enforcement Planning Agency. This program also has formal meetings with members of the State's Coalition Against Domestic Violence who act as advisors to Title XX, with the Department of Public Welfare concerning assistance payments, and with the Department of Education regarding school issues for children in shelters. Respondents from Title XX programs in several States reported they hold meetings with the staff of spouse abuse programs to coordinate activities and develop better communication. Other State Title XX programs coordinate with agencies, such as Child Protective Services (CPS), Councils on the Status of Women, Divisions of Children and Youth, Family and Children Bureaus, Food Stamp offices, LEAA, and school systems, to consider and resolve overlapping problems concerning battered women and their families. In many instances, Title XX program staff assumed the initiative for these activities.

Based on discussions with State level Title XX respondents, it appears that much of the ongoing coordination activity occurs at the local level. Several State respondents specified that local program staff work closely with staff from various other community agencies, such as welfare departments, mental health agencies, private clinicians, shelters, and police departments. However, based on responses from the local social services programs surveyed, coordination activity is more limited than it is perceived to be by the respondents at the State level. Many local respondents mentioned referral activities; however, there is little coordination subsequent to initial referrals. Only a few local staff identified coordination activities with agencies such as law enforcement groups and mental health centers.

On the State level, 46 percent of Title XX program respondents noted that some of their staff members are advocates for battered women. Respondents from two of the five APS programs surveyed also reported that they have staff who advocate for battered women's services. On the community level, staff from 36 percent of the local programs reported having staff who encourage assistance to battered women. Some staff are advocating for inclusion of domestic violence services in the Comprehensive Annual State Plan. Others have worked to develop specific direct services, such as safe homes or emergency shelters for adults, or have encouraged provision of training on domestic violence for social services staff. Lobbying for legislation related to services for battered women is another area where local staff are vocal. Some of this advocacy by staff takes place within their own agencies; in other cases, it occurs through staff involvement in grassroots organizations.

In a high percentage of Title XX funded programs at both the State (80%) and local (67%) levels, staff are aware of external advocacy groups for battered women. Advocacy groups reportedly are involved in community awareness activities and in legislative advocacy and are successful in focusing attention on domestic violence victims. They also have helped to establish direct services for battered women, specifically safe homes, shelters, counseling, legal aid, and supportive services. According to respondents, advocacy groups also have raised funds both for direct services and for research on domestic violence. Finally, external advocacy groups are credited with facilitating the coordination of services for battered women through their involvement in program planning, education, and the establishment of referral and service provision networks.

Barriers to Service Delivery

On the State level, 72 percent of the Title XX program respondents identified Federal, State, or program barriers which restrict provision of services to battered women. On the community level, approximately one-half (53%) of the Social Services staff identified similar barriers to serving battered women. In analyzing respondents' comments on barriers, several broad categories emerge. First, Federal funding levels and funding procedures are perceived as a major barrier to providing services to battered women through Title XX. Respondents reported that the Federal ceiling set on Title XX funds does not take into account the need for services to abused spouses. In some cases, the Federal/State funding match requires an unusually high percentage of State funds, barely enabling the State to maintain its present level of services. One respondent said that the requirement of a local funding match for optional services is a barrier. Also, at the current funding levels, other optional services would have to be decreased to add services specifically for domestic violence victims. In addition, the Federal funding process makes it very difficult to plan services; State level administrators reported they cannot obtain information about the amount of funds allocated to their States far enough in advance.

Respondents perceived some additional Federal level restrictions. There is no Federal mandate to provide services especially for battered spouses, through Title XX, and in the past, Title XX regulations prohibited reimbursement for emergency shelter care for adults, except where such care is an integral but subordinate part of a service package as defined in the Federal regulations. Some respondents also felt that Federal Title XX guidelines for income eligibility prevent many domestic violence victims from receiving services.

Respondents from both State and local programs also cited State level barriers to serving battered women. Often, State funding levels preclude any targeted services. In many States, legislation provides no funds specifically for services to victims. In some States, provision of emergency shelter is tied to protective services clauses in State legislation, but domestic violence is not incorporated into these definitions. For example, under APS, eligible individuals often must be certified as physically or mentally impaired and unable to serve their own interests.

State policies sometimes present barriers to Title XX services. For example, one State does not permit "room and board" payment through Title XX for a child who accompanies his/her mother to a shelter, and payment for room and board is limited to a 30 day maximum. In many States, services to battered women are not incorporated into the Comprehensive Annual State Plan (CASP) and, thus, are not built into the Title XX service delivery system.

The Title XX funding priorities established by States are frequently cited as barriers to implementing services for battered women. Some States emphasize the use of Title XX funds for children's services and, in turn, neglect services for adults. Priorities on other population groups, such as the elderly or disabled individuals, also may deter Title XX services for domestic violence victims. In setting priorities for services, many States do not recognize domestic violence as an area of need.

State, like Federal, guidelines for eligibility may preclude services to domestic violence victims. In addition, State policies often limit or eliminate services needed by battered women. For example, some States do not allow the use of Title XX funds for crisis intervention services or transportation. One State has a policy eliminating the social service component from local assistance boards so that no direct services or home visits by staff are allowed. Other States do not permit funding for work performed by staff after normal working hours.

On the local level, there is not always a clear understanding by staff of policies and eligibility requirements applicable to battered women. Differing interpretations of program regulations were also cited: inconsistent interpretations of payment limits for room and board, limitations imposed on shelters regarding use of Title XX funds, and reimbursement policy changes related to length of stay in shelters and to children's stay in shelters. Other barriers mentioned were: lack of staff expertise; staff's belief that it is not their responsibility to work with domestic violence victims, large caseloads, lack of community demand for services, and lack of coordination with other services.

Difficulties in coordinating services of various providers were often cited as a barrier to helping battered women. Related to this problem is the coordinating cost, particularly in terms of staff time. This relates to some respondents' concern that already scarce funds are spent on administration rather than service provision.

Eligibility requirements tie in closely with Federal, State, and program level barriers and also present barriers to serving battered women. Title XX services have income eligibility criteria which prohibit services to more affluent battered women, if the State decides not to provide these services without regard to income. One State respondent cited a unique situation related to income eligibility: a battered women is technically eligible for room and board and crisis counseling based solely on the need for protection; however, once she enters a shelter, Title XX reimbursement for supportive services provided by the shelter is based on her income. Title XX services also have State-determined categorical eligibility criteria, and if women do not fit these categories, they cannot receive services. Many States also have

residency requirements; women not residing in the State or without permanent addresses in the county are ineligible.

Other types of program eligibility criteria also pose problems. For example, according to several local respondents, battered women are not eligible for any specific services unless they have children and the children are "in danger." Respondents from another State indicated that, because it routinely takes 30 days to establish eligibility, Title XX cannot effectively provide crisis intervention services to battered women.

As previously discussed, Title XX respondents in both States and communities were asked if they believe it feasible for their programs to assume (additional) activities for battered women. Those who believe it is not feasible cited a number of reasons, many related to barriers already mentioned. The most frequently cited reason is the limitation on Title XX funds. Many respondents indicated that budget cuts have already necessitated a cutback in overall services. They believe that the existing services would have to be further reduced to permit services focused on battered women. Respondents believe they would be put in the untenable position of placing a higher priority on battered women than on other groups, such as abused children or the elderly. The lack of domestic violence incidence data to support a special effort for battered women exacerbates this problem.

Other respondents cited funding limitations, in combination with the presence of other agencies to serve battered women, as restricting the Title XX program from focusing on this population. In one State, when legislation was passed appropriating funding for shelters, Title XX funds for services to battered women were eliminated. Other respondents believe that battered women already have laws to protect them and special women's organizations and mental health centers to provide aid; thus, Title XX funds are better used to meet other needs.

Few staff and lack of staff training oriented toward domestic violence are also cited as limiting Title XX programs' potential to serve battered women. Many respondents indicated that their programs simply do not have sufficient staff to provide these services. Others believe that private agencies with staff specifically trained in domestic violence issues can serve battered women more effectively.

Program Recommendations to Enhance Service Delivery

During the course of interviews with State and community staff of Title XX programs, a number of recommendations were made with respect to enhancing services for domestic violence victims. First, staff identified resolutions or planned resolutions for some of the barriers prohibiting Title XX services to battered women. One resolution frequently mentioned was passage of HR 3434 on the Federal level. This bill, P. L. 96-272, which was passed in the summer of 1980, provides for Title XX reimbursement of emergency shelter for adults as a protective service. A few respondents mentioned attempts to pass State legislation to resolve barriers. One State is considering a plan to cease receipt of Title XX funds. Instead, social services would be exclusively State-funded to facilitate services to specific target groups such as battered women.

Respondents also proposed some changes which are not yet in progress but would facilitate provision of services to battered women. Again, the most frequently mentioned change relates to an increase in funding and a concomitant increase in staff. Second, a Federal mandate to serve domestic violence victims or, alternatively, placing a higher priority on this issue at the State level and including domestic violence services in the CASP, were noted as crucial. Other respondents view implementation of staff training as necessary to enhance services for battered women. A number of respondents also recommended that a specific program or unit be established to provide services to victims of domestic violence. Others suggested that alterations in the State Title XX program, for example, de-emphasizing children's services and emphasizing services for adults, might be necessary. Changes in the eligibility criteria, both income and categorical, also were suggested.

More effective coordination is viewed by many respondents as necessary, if services to abused spouses are to be improved. The need to enhance service providers' knowledge of all available services to facilitate the referral process and make service delivery to battered women more comprehensive was most frequently identified. There were also several suggestions made as to methods for doing this. One respondent, for example, suggested meetings involving representatives from as many programs as possible to discuss available services, the service delivery system, and problems encountered. Another said that technical assistance could be provided to counties to enable them to develop local comprehensive service plans. Still another indicated that training for staff of the county office both to sensitize them to domestic violence issues and to train them in services and referral procedures to other community agencies would be helpful. The possibility of establishing a domestic violence task force on the county level was mentioned; this task force would take the lead in coordinating services. One respondent suggested that Title XX program administrators form an advisory board to facilitate coordination of services for battered women. Another respondent recommended that all local agencies contribute resources toward the establishment of a domestic violence intervention center. Another idea was to have a State coalition representative work in the Governor's Office as an ombudsman, specifically to provide information and resolve problems related to domestic violence. Several respondents noted concern about coordinating with law enforcement officials in their States and communities, including the need to train law enforcement officers in domestic violence intervention techniques.

In many cases, respondents believe that training of Title XX providers is important if services to battered women are to be enhanced. Information on service delivery strategies also is seen as important, including training on how other States and communities are dealing with the problem of domestic violence, program planning and development, needs assessment, and making use of community and agency resources.

Respondents on both the State and community level identified some ongoing efforts which may enhance service delivery to abused spouses. Many of these efforts involve State legislation related to the domestic violence issue. For example, several States have legislation pending to allocate funds for domestic violence programs. One of these is a marriage license surcharge bill which would generate funds for rape and domestic violence programs.

Another State has an Adult Protective Services bill pending. Yet another State has recently passed a law concerning temporary restraining orders; this law is intended to help keep the abuser away from the victim and facilitate the process for a victim who wants to file charges against the abuser. Most of the other efforts mentioned involve the establishment of new programs that provide direct services to victims, such as emergency shelter and counseling. Respondents believe these programs will help alleviate the pressures of their caseloads, provide them with referral sources, and also serve battered women not eligible for Title XX services.

SUMMARY

There appears to be broad variation among Title XX programs in terms of responsiveness to the needs of battered women. In general, State program administrators reported more involvement in this issue than local staff. Of all the activities assumed by program staff, coordination is the most frequent. While some staff are actively involved in funding shelter care and providing direct services to battered women, others either do not identify domestic violence as a service priority or believe that Federal, State, or other barriers preclude the use of Title XX funding for services to domestic violence victims.

There are some indications that Title XX has considerable potential to become more consistently and actively involved in providing services to victims and their families. To date, individual State priorities and/or staff concerns are providing the impetus for these activities.

THE WORK INCENTIVE PROGRAM (WIN)

AUTHORIZING LEGISLATION

Title IV-A, Social Security Act of 1967

FEDERAL AGENCY RESPONSIBLE

National Coordination Committee, Office of the Work Incentive Program, Department of Labor - Department of Health and Human Services

PROGRAM OVERVIEW

The WIN program is jointly administered at the Federal level by the Department of Labor and the Department of Health and Human Services (DHHS). This study focuses only on that portion of the WIN program which provides social services through DHHS. The WIN program provides employment and training services and supportive social services to eligible clients of Aid to Families with Dependent Children (AFDC) to facilitate their movement toward work and self-sufficiency.

The supportive social services provided by WIN include child care, family planning, employment-related medical care, counseling, vocational rehabilitation services, home management, and in some cases, financial assistance until recipients receive their first pay checks.

ABSTRACT OF MAJOR PROGRAM FINDINGS

The findings presented in this abstract and subsequent discussions are based on interviews conducted with State level WIN administrators in 49 States* and the District of Columbia and with local WIN program administrators and direct service staff in 29 communities.

Based on interviews with State and local WIN program representatives, the following findings are reported:

- In one WIN program surveyed at the community level, staff have developed goals to address the needs of battered women.
- WIN program respondents in 10 percent of the States and seven percent of the communities surveyed reported that staff provide direct services to battered women.

*WIN program administrators in one State did not participate in the State Survey.

- WIN program respondents in 16 percent of the States and 38 percent of the communities surveyed reported involvement in coordination activities directed at the problem of domestic violence.

- WIN program respondents in 28 percent of the States and 24 percent of the communities surveyed reported that staff have received training to better understand abused spouses and their families.

- In 18 percent of the State and 38 percent of the community programs surveyed, WIN program respondents identified staff who encourage assistance to battered women.

- WIN program respondents in 76 percent of the State and 66 percent of the community programs surveyed are aware of advocacy groups in their States and/or communities which assist abused spouses.

- WIN program respondents in 46 percent of the States and 62 percent of the communities surveyed view Federal or State regulations, policies, and guidelines as restricting staff capacity to address the needs of battered women.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

As evident from the statistical summary presented above, few WIN program staff are directly involved in efforts to assist abused spouses and their families. This section describes the potential of the WIN program to become more involved by examining the activities of those WIN staff engaged in efforts to help battered women. In this context, the barriers to service delivery identified by WIN respondents as well as their recommendations for improving service for abused spouses are discussed.

Specific Program Efforts

By Federal regulation, the WIN program targets on AFDC recipients. Within this mandated service population, no WIN respondents at the State or community program levels identified a focus on battered women, their children, battered men, and/or abusing spouses. None of the WIN respondents reported a program definition of domestic violence nor did any identify program goals or objectives developed to address the needs of victims.

Several WIN respondents reported that some of the program's general goals and objectives could apply to meeting the needs of battered women. For example, one major objective of the WIN program is to remove barriers to employment. Thus, WIN staff could assume responsibility for assisting battered women in resolving this problem. In fact, one State administrator reported that WIN funds all services for spouse abuse victims enrolled in WIN; in this case, "battering" is viewed as an employment barrier.

Further, battered women who also are WIN participants are elibible to receive the same services as other WIN participants. Some WIN staff at the local level indicated that during the intake process, battered women are

identified. Specifically, WIN program staff in nine communities (31% of the Community Survey sample) indicated that intake procedures include identification and referral of battered women. Respondents in these nine programs were queried about what types of problems are presented by battered women when they apply to the WIN program. Primary problem areas, that is, those which were presented by 60 percent or more of the battered women, include other types of marital problems, unemployment, emotional abuse by the spouse, and the need for legal protection from the spouse.

Nine programs at the State level (18%) and three programs at the local level (10%) have staff engaged in activities related to the problem of spouse abuse. At the State level, activities include collection of statistics (2%), assessment of needs (4%), community education (4%), training, and technical assistance (2%). In one State, WIN program staff collect statistics on clients who are receiving counseling services related to domestic violence problems. In two other programs, staff have conducted assessments to determine the services most needed by battered women. Staff from one of these programs also conducted, in conjunction with the needs assessment, community education on the needs of multi-problem families, including families experiencing domestic violence. In another State, staff have developed a training program on "single parenting," which deals with the problem of domestic violence. The respondent from this State indicated that future plans include more training on the problem of spouse abuse.

Administrators in two States have taken special initiatives for the WIN program to assist battered women. In one State, a staff specialist is assigned to work with domestic violence victims enrolled in the WIN program. In another State, a local WIN program submitted a proposal to DHHS to establish a domestic violence project to respond to the high percentage of abused spouses within the WIN client caseload. The proposed project would facilitate WIN staff coordination with shelter program staff to help battered women and their families.

Results form the Community Survey indicate that staff from three programs at the local level (10%) engage in activities directly related to the needs of battered women. These activities include providing direct services to battered women and operating a clearinghouse for information on domestic violence. Program representatives also were queried about the feasibility of their programs to assume additional activities on behalf of abused spouses. Most WIN program respondents indicated this is not feasible. The reasons given by both State and community program representatives are similar and can be related to several general themes, including:

- A sufficient demand for services to battered women has not been demonstrated.

- WIN is a short-term employment program and is not designed to meet the multiple social service needs of battered women.

- A lack of program resources (e.g., funding, staff, training).

Those program representatives, who consider it feasible for the WIN program to expand services to battered women, usually suggested that WIN become more involved in direct serivces and coordination activities. An expansion of training and program planning activities also was mentioned, although less frequently.

Perhaps the greatest potential for expansion of program services lies in WIN staff participation in coordination activities. Although the number of WIN staff currently involved in coordination activities aimed at helping victims is limited, on a relative basis a greater proportion of WIN program staff are involved in this activity than in any other. Eight State programs (16%) and 11 community programs (38%) reported such involvement. None of the WIN programs at the State level but five of the community programs (17%) have developed interagency service agreements to better serve battered women. Informal meetings also are used to develop linkages, as reported by five State level and three community level WIN respondents. Most coordination activities are with shelter programs, other social service agencies and/or mental health agencies. In addition, a few local WIN program staff reported linkages with displaced homemaker programs.

Some WIN staff also serve as advocates for abused spouses and their families. In nine WIN programs at the State level (18%) and in eleven programs at the community level (38%), there were staff identified as advocates for services to battered women. At the State level, advocacy efforts by administrators include:

- Participation in community education efforts.
- Development of coordination linkages.
- Serving on the Board of Directors for shelters and women's resource centers.
- Developing program proposals to promote and describe WIN services available for battered women.

At the community level, most of the advocacy activities involve direct contact with battered women or with other staff serving battered women.

WIN respondents generally are aware of other advocacy efforts occurring within their State and community to assist abused spouses. Respondents attribute these advocacy efforts to increased public awareness about the problem, the formation of safe homes or shelters, and, in a few instances, provision of counseling and legal serices to battered women.

In brief, in only a few instances are WIN program staff involved in any activities directed toward battered women. The following sections highlight barriers to service provision and possible resolutions to these barriers as identified by respondents.

Barriers to Service Delivery

In almost one-half of the WIN programs at the State level (46%), and in almost two-thirds of the programs at the community level (62%), respondents identified barriers which impede service provision to battered women, resulting from Federal or State legislation, regulations, and guidelines. Generally, more WIN program representatives at the community level than at the State level cited barriers to service provision.

Overall, the general types of restrictions cited by State and community respondents are similar (e.g., funding, eligibility requirements). The major barrier cited at both the State and community levels is an overwhelming lack of resources to support service provision. Lack of funds, combined with staff shortages, severely limit the extent to which WIN can assist abused spouses. Respondents added that staff are not trained to counsel battered women, and poor linkages among WIN and other services generally result in an ineffective use of the limited resources available in the community.

Other major barriers, identified by State and community staff, result from the WIN eligibility requirements. Specifically, WIN eligibility criteria are linked to AFDC eligibility. Thus, women without children or with financial assets beyond a certain level, cannot receive WIN's work-related services. In addition to being an AFDC recipient, the battered woman also must be assessed as "employable." One respondent noted that battered women often need to resolve psychological and/or medical problems before they can be considered employable. Usually, WIN program resources are not adequate to assist these women; thus, they remain in the "exempt from employment" status. Several respondents also mentioned that Federal guidelines and regulations preclude targeting services on battered women.

Another barrier to serving battered women results from the manner in which the WIN program is administered. The WIN program is jointly administered by DHHS and the Department of Labor. One WIN staff respondent stated that the two departments work at cross purposes with conflicting philosophies: the employment side of the WIN program emphasizes immediate job placement, whereas the social service side focuses on resolving problems prior to the client entering employment. As another respondent noted, WIN is funded on the basis of productivity and successes, not on the basis of the number needing services. Emphasis is placed on obtaining employment for a battered women, or any WIN client, immediately. If the battered woman is not readily employable, she may not receive any services. Instead, she may be placed in the unassigned recipient pool, a holding pool for less employable WIN clients. This conflict between the social service side and the employment side sometimes emerges during the joint appraisal session, which includes a social services worker, an employment and training specialist, and the client.

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Program Recommendations to Enhance Service Delivery

Overall, WIN program staff had few suggestions for improving WIN services to battered women and their families. ALthough some respondents mentioned that staff are sensitive to the needs of battered women and that they are exploring possible strategies to meet these needs, more than one-half of the respondents do not think it is appropriate and/or feasible for WIN to expand service provision to battered women.

Other program staff cited specific changes which might enable the WIN program to serve battered women more effectively. These suggestions essentially involve removal or resolution of those barriers described previously. Generally, State level staff suggested changes in Federal regulations and guidelines which would allow targeting specific services for battered women. Program staff at the community level also suggested changes in the Federal progam mandate. In addition, these staff emphasize the need for increased funding and other necessary resources to support service provision to abused spouses.

A majority of the staff at the community level cited the need for training and technical assistance to understand better the needs of battered women and their families. The following are training topics suggested by State and local WIN program staff.

- The dynamics of domestic violence.
- Identification of domestic violence victims.
- Development of staff sensitivity to and awareness of the problem.
- Interviewing and intervention techniques with abused spouses.
- Use of local resources and referral alternatives.

In conclusion, several different types of changes were recommended to improve WIN's ability to serve battered women. At the same time, about one-half of the WIN respondents surveyed were reluctant to make any suggestions, because they do not view WIN as the appropriate program to deal with battered women.

SUMMARY

At present, WIN program staff are minimally involved in activities related to the problem of spouse abuse. The potential of WIN staff to increase their activities appears greatest in the area of service coordination with other programs. In some instances, battered women technically eligible for WIN services are considered "unemployable" by staff. This factor, as well as the focus on AFDC recipients as the program's target population, seems to deter staff efforts to identify and help the victims within their mandated service population. WIN staff, especially at the local level, indicated their desire to receive training and technical assistance to increase their capacity to help battered women.

THE INDIAN HEALTH SERVICES PROGRAM

AUTHORIZING LEGISLATION

Indian Self-Determination Educational Assistance Act, P.L. 83-568

FEDERAL AGENCY RESPONSIBLE

Indian Health Services, Health Services Administration,
Public Health Service, Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

There are two major Indian Health Services (IHS) programs, the Health Management Development Program and the Sanitation Management Development Program. The Health Management Development Program, which is the basis of this study, has the twofold purpose of raising the health level of Native Americans through rehabilitative health services and building the capacity of Native Americans to manage their health programs. Federal grants are made to "Federally recognized tribes and tribal organizations" in order to establish and operate IHS facilities (hospitals, health centers, etc.) and/or to purchase contracted health services.

IHS services are available to American Indians or Alaska Natives; however, since grants are made to recognized tribes, the population served is primarily Native Americans who reside on reservations.* In general, any member of the more than 250 Federally recognized tribes, including Alaskan Natives, is eligible for medical care and supportive services through IHS and theoretically can receive care at any of the 88 IHS Service Units. However, when services are delivered through tribal contract, the services may be limited by more stringent service eligibility criteria, such as specific tribal membership. Some legal questions pertaining to "Who is an Indian?" currently are being considered by the courts. The answers to these questions may increase the number of persons eligible for IHS services in the future.

Under the Health Management Development Program, the following health services are provided: public health nursing, maternal and child health care, dental and nutritional services, psychiatric care, and health education. The program focuses on primary and episodic medical care with a variety of supportive services, including social services. Because reservations are located primarily in rural areas, the development of self-contained, comprehensive,

* There are approximately 700,000 American Indians and Alaska Natives, the majority of whom live on reservations, in small rural communities, or in isolated villages. About 75 percent of the Native Americans reside in the South and West U.S. Census Bureau Regions, and more reservations are located west of the Rocky Mountains than in any other area.

on-site health facilities has been necessary. The IHS currently supports over 50 hospitals and nearly 100 health centers.

IHS is organized by Area or Program Offices. Defined geographically, an Area or Program Office can have responsibility for Native Americans residing in more than one State, portions of one or more States or both. Each Area or geographic area has a concentrated Native American population. On occasion, one Service Unit may serve a number of small reservations, or, as with the Navajo people, several Service Units may serve one tribe. A Service Unit usually contains an IHS hospital or health center. The Social Services component of IHS has at least one service worker at each of the 88 Service Units. The Chief of the Area Social Services Branch serves as a consultant, advisor, facilitator, evaluator, and monitor to the Social Services staff at the Unit level. Service Units frequently have Tribal Health Boards which serve in an advisory capacity.

ABSTRACT OF MAJOR PROGRAM FINDINGS

Indian Health Services has eleven Area or Program Offices. For the State Survey, at least one respondent from each Area Office was interviewed. Most of the respondents were the Chiefs of the Area Human or Social Services Branch, within their respective offices. In the Community Survey, only those IHS programs falling within the sampled sites could be selected. IHS programs in five out of six communities were operational at the time of the survey. Highlights from the survey of Area and Program Offices are presented below:

- None of the Area Offices have a definition of domestic violence or specific objectives related to services for battered women.
- Slightly more than one-quarter of the Area Offices (29%) focus on battered women, children of battered women, and/or battered men.
- Although IHS programs do not have any mandated responsibilities directed toward battered women, 64 percent of the Area Offices have undertaken some activities on their behalf.
- Half the Area Offices (50%) have developed coordination linkages with other programs or organizations on behalf of battered women.
- In 50 percent of the Area Offices, program staff have received some type of training and/or technical assistance to better understand the needs of battered women and their families.
- A substantial majority (86%) of the Area Offices identified staff who encourage IHS assistance to battered women.
- In over three-quarters of the Area Offices (79%), respondents identified external groups active in promoting services for battered women.

- Fourteen percent of the Area Office respondents identified restrictions to their programs' capacity to assist battered women and their families which stem from Federal or State legislation, regulations, etc.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

The following sections of this analysis examine three major areas pertaining to IHS' potential to serve battered women and their families: the types and scope of specific IHS program activities currently undertaken to deal with domestic violence; barriers to service delivery identified by program respondents; and recommendations from program respondents for enhancing the delivery of services to battered women.

Specific Program Efforts

There are no IHS mandated services or activities directed toward battered women and their families as a specific population group. However, in 29 percent of the Area Offices, respondents reported a specific focus on battered women (14%), children of battered women (14%), and/or battered men (7%).

IHS programs engage in various activities to help battered women, even though a specific focus on them as a distinct group may not be present. Nine Area Offices surveyed (64%) engage in various activities for battered women; for example, staff training, technical assistance and consultation to individual programs, program planning, and community (tribal) education. Direct services are provided to battered women by 21 percent of the Area Offices. At the community level, IHS programs sometimes collect statistics on the incidence of domestic violence, including those involving the use of alcohol; these local programs also participate in coordination activities with other programs to benefit battered women. Staff in the community programs reported that a significant portion of their caseloads includes battered women. In one instance, 40 percent of current clients were identified as female victims of battering. The IHS services available to these women include counseling, advocacy, and referral. No IHS-funded programs target services specifically on battered women. However, in August 1980, a Family Crisis Center opened in one community. It is the first and only program located in an IHS facility that targets services on families in crisis, including families experiencing incidents of spousal abuse.

Three of the community programs surveyed attempt to identify battered women in their intake and assessment procedures. When asked about the types and frequency of problems battered women present, respondents in these programs indicated that alcohol abuse and emotional abuse by the spouse are experienced by more than 60 percent of the battered women encountered. All IHS respondents surveyed also stated that alcohol abuse appears to be a significant contributing factor to the incidence of domestic violence among Native Americans and that it is difficult, if not impossible, to get abusing spouses to accept any form of counseling.

Some program staff believe it is feasible for the IHS program to assume additional activities to help meet the needs of battered women and their families. Those activities identified most often by respondents include the collection of statistics, program planning, technical assistance and consultation, and some direct services; e.g., counseling.

Fifty percent of the programs at both the Area Office and community levels participate in some type of coordination activities on behalf of battered women. Most frequently, informal meetings are used to coordinate activities with various State and county agencies. Less frequently, IHS offices have a service or confidentiality agreement with other agencies, share staff with other agencies or participate in a task force or committee established to coordinate activities for battered women.

Where possible, Service Unit staff have established referral linkages between Native American women and shelter facilities in nearby communities. Social services provided through Title XX are often made available to Native American battered women through referral by Service Unit staff. It is difficult, however, for most Service Unit staff to develop these linkages. Service Units are usually located in rural areas, where social services, in general, are limited. Further, shelters in large urban areas are frequently overcrowded, have "waiting" lists, and Native American women are often unwilling to leave the familiar environment of the reservation, even when they need the safe surroundings provided by temporary shelters.

Respondents indicated that community support is very important in the establishment of linkages with non-IHS programs. On one reservation, where the community and tribal government are actively involved in providing services to battered women, IHS staff participate in a grassroots-generated program that has developed a comprehensive network of services. This network includes an on-reservation shelter, transportation services, services for children, and legal services. The tribal court in this Area has recently mandated that abusing spouses participate in counseling and support group activities.

In the community programs, the staff were asked to identify the providers to which battered women are referred. Universally mentioned were mental health services, alcohol and drug treatment services, and services for battered women (e.g., shelters).

In most Area Offices, respondents indicated that there are both Office and field staff who consistently advocate for battered women's services. Among Area Office staff, the advocacy efforts tend to focus on technical assistance to local programs, Federal funding for increased activities, and community education. Among local Service Unit staff, individuals have: helped grassroots organizations establish domestic violence programs, including shelters; provided services specifically aimed at battered women, e.g., counseling; and engaged in community (tribal) education about domestic violence and the resources available to victims.

Barriers to Service Delivery

IHS respondents identified diverse sources of barriers to delivering services to battered women and their families: programmatic restrictions, paucity of resources, tribal autonomy, cultural taboos, and attitudinal barriers. A few respondents perceived a conflict between the Indian Health Services and the Bureau of Indian Affairs (BIA) about which group should deliver social services. Since IHS is primarily a provider of health services, jurisdictional questions arise over the provision of social services.

In addition, community program respondents mentioned two operational problems inherent to their program. The first relates to a Federal restriction against hiring additional staff. Frequently, there is only one social service worker per Unit. Further, the lack of trained personnel, particularly Native American staff, affects the program's capacity to deliver even limited services. A second barrier results from the screening and referral procedures which the medical staff must follow in making referrals to the social services staff. Victims, who show medical evidence of physical abuse or who are otherwise identified by medical staff as battered, may be referred to social services for other assistance. If such identification does not occur on the clinical service side, or referrals of suspected victims are not made, then victims are not served by the social services staff. This practice places major responsibility for the identification and referral of battered women on the medical service staff.

Funding constraints severely limit programmatic response to the problem of domestic violence. All community respondents agree that domestic violence is chronic and widespread, and includes not only battered women, but also battered or abused parents, especially elderly parents. The need and demand for services is apparent, according to IHS respondents, but they note that funds to develop programs for or expand services to these victims are insufficient.

According to IHS respondents, one of the primary barriers to delivering services to victims of domestic violence--the abused and the abusers--can be the tribal peoples themselves. The issue of tribal autonomy, not yet entirely resolved, means that programs, for the most part, must be community-based to be acceptable. One ramification of this particular issue extends to the prohibition against non-tribal police intervention on the reservations. If tribal police do not intervene in a domestic violence incident, the victim has no protection. Native American cultural attitudes and unique life style contribute to the reticence of and resistance from tribes concerning discussion of domestic violence problems. For example, articulating a problem that may bring shame on a family or clan is not considered acceptable behavior in Native American culture.

Program Recommendations to Enhance Service Delivery

IHS staff recommendations to enhance service delivery focus on steps which are necessary for better coordination of services, changes that are needed on the reservations and within the IHS program, and training and technical assistance to increase staff capability to help victims and their families.

Respondents suggested that increased staff and tribal training and the development of coalitions among providers and victims would promote better coordination of available resources. In addition, it was recommended that the jurisdictional problems between BIA and IHS concerning responsibilities for social service delivery be resolved.

Repeatedly, respondents noted the need for consent of the tribal government to deliver services to battered women on the reservations. The tribal autonomy of the Native Americans, combined with the physical isolation and remoteness of the reservations, severely limits the potential usefulness to Native Americans of any services not located on the reservation. Even those services housed on some tribal lands may be accessible only to a portion of the population because of the great distances on large reservations. Without consent from the Tribal Council, or its equivalent, IHS activities for battered women, according to respondents, will continue to be minimal.

Funds to initiate selected services or expand existing services are viewed as critical by respondents. The following examples provide insights into the dilemmas faced by some program staff in their attempts to serve domestic violence victims. Line staff in one Area receive considerable support for their program activities to benefit battered women from the IHS Area administrator. However, the tribal governments on reservations in this Area are not willing to discuss the problem of domestic violence with IHS staff. In one Service Unit, the social service caseload is composed of more battered women than any other group, but staff are continually frustrated in their attempts to find funds that would allow the development of a domestic violence program or services specifically related to those victims.

Another IHS Area has developed an excellent service network with grassroots organizations on the reservation, but the model developed by the grassroots program does not have adequate funding. The director of the grassroots program and the IHS staff believe the model can be implemented on any reservation in the country, with minimal funds.

Other recommendations involving programmatic changes focus on staff training and education about domestic violence, implementation of needs assessments specific to the tribe or reservation, and tribal outreach and education.

SUMMARY

While IHS has no mandated services or programs on behalf of Native American battered women, some IHS administrators and service staff have become actively involved in advocating for services and in attempting to find non-IHS funding sources for program development. Service Unit staff are involved, in varying degrees, in direct service delivery, support services, and/or advocacy. For example, one IHS staff worked over a period of four years to develop and obtain funding for a Family Crisis Center in one IHS hospital. Concomitant with such activity, there is a high level of frustration among many IHS service staff, because they are so limited in their ability to provide services. Yet, the IHS program appears to have potential to serve battered women in the client population because of its health and social services orientation.

DOMESTIC VIOLENCE INTERVENTION ACTIVITIES ON TWO AMERICAN INDIAN RESERVATIONS

INTRODUCTION

As part of the Community Survey field effort, CSR purposively selected two American Indian Reservations for in-depth study of activities related to the problem of domestic violence. The reservations selected were: The White River/Fort Apache Reservation (the White Mountain Apache Tribe) located in Arizona; and the Rosebud Reservation (the Rosebud Sioux Tribe) located in South Dakota. In addition, the community surrounding the Rosebud Reservation, Todd County, also was purposively selected for in-depth study.

Indian Health Services (IHS) staff working in IHS hospitals were interviewed at both reservations; domestic violence program staff were interviewed at the Rosebud Reservation; and Medicaid, Child Protective Services (CPS), and Title XX program staff were interviewed in Todd County. Further, informal discussions were held with six Native American women who had experienced spousal abuse.

This report presents the findings of these interviews and discussions and is organized with regard to: the scope of IHS program efforts; barriers to receipt of services; actions taken by program staff to enable service delivery to battered women; and, program coordination linkages.

RESERVATION OVERVIEW

Both the White River and Rosebud Reservations are located in isolated and rural areas of their respective States. Transportation from the Reservations to other areas must be arranged through private means and is often expensive. Lack of employment opportunities and unemployment are chronic problems experienced by tribal members. The rate of unemployment, especially for males, is approximately 25 to 35 percent. This is more than five times higher than State unemployment rates in Arizona and South Dakota. (The States' unemployment rates average between five and seven percent.)

The total on-reservation population at Fort Apache/White River is approximately 8000, and at Rosebud, it is slightly over 7000. Each Reservation has an IHS hospital with a Social Services staff of five to six individuals, including office support staff. Other data obtained about the Reservations' residents included that their death rate from traffic accidents and from cirrhosis is three times higher than that of their local non-Indian peers. In addition, the Reservation residents' rate of infant-mother mortality is considerably higher and their life expectancy is significantly lower than that of the residents of the two communities which surround the Reservations.

SCOPE OF PROGRAM EFFORTS

With regards to IHS efforts, neither Social Services program surveyed has a Board of Directors or similar advisory body. The programs also do not have any definitions of domestic violence nor are they under any mandate to provide services specifically to battered Native American women.

Staff members from both IHS programs have received some special training, mostly in the form of seminars and workshops, aimed at increasing their understanding of domestic violence and the special needs of battered women and their families. In addition, staff from both programs have assumed active roles in behalf of battered women. Staff activities include: counseling services for victims; community education; domestic violence program planning; and client advocacy.

BARRIERS TO SERVICE PROVISION

One of the major barriers to the development of domestic violence programs or to services targeted specifically on battered women, as experienced by both IHS facilities, is the lack of funds. Despite this barrier, IHS Social Services staff members from each facility are outspoken advocates for the development of services for battered women. However, the outcome of these advocacy efforts differs dramatically on the two Reservations under study, and appears to be related to the respective Reservation's response to these efforts. Further, it appears that the successes and failures of IHS advocacy efforts are directly related to the tribal people, themselves.

At the Fort Apache/White River Reservation, the IHS Social Services caseload is comprised of more than 40 percent of battered women. This percentage does not include the battered women who are clients of the Tribal Guidance Center. At the Rosebud Reservation, the IHS caseload of battered women is slightly less than 40 percent. However, the similarity of the Reservations with respect to domestic violence ends here.

At Fort Apache/White River, the tribal government, the various tribal programs, and the Reservation community, all fail to recognize domestic violence as a serious and severe problem. Further, there is a great reluctance at all levels to even discuss the problem.

Two IHS White River Hospital staff, most active in behalf of Native American battered women, are trying to obtain funds for an on-reservation shelter. (The shelter now nearest to the Fort Apache Reservation is 150 miles away.) Thus far, the IHS staff have been unsuccessful in these efforts. They expressed their ongoing frustration with the tribal government's resistance to establishing a shelter and with the tribal women, themselves, who are afraid to speak up due to a variety of socio-cultural reasons. IHS staff are attempting to develop the strength and the commitment of battered tribal women through peer and mutual support counseling groups. However, the IHS staff also expressed the opinion that their efforts would be generally ineffective, unless there was extensive "community" education and Reservation involvement.

In contrast, at the Rosebud Reservation, there is strong and active grassroots tribal involvement directed toward meeting the needs of battered women. For example, the White Buffalo Calf Women's Society was formed in 1977 by women of the Rosebud Reservation who were concerned about problems affecting women, children, and families. Gradually, the Society was successful in overcoming the resistance of the tribal government and the tribal police.

During the first week of October, 1980, the Society opened a Family Violence Center, funded by small grants from private foundations, which, in turn, established an on-reservation shelter. Further, the Tribal Council recently passed a Resolution which mandates that victims and their abusing spouses seek counseling services from the Family Violence Center. (A copy of this Resolution is attached to the end of this report.) IHS staff are members of the Center's Board of Directors, are one of the primary providers of the Center's counseling services, and also engage in direct family crisis intervention. Further, IHS staff are available to assist Family Violence Center staff at all times.

ACTIONS TAKEN BY IHS STAFF TO ENABLE SERVICE PROVISION

At Fort Apache, IHS Social Services staff have engaged in advocacy efforts, both within and outside the IHS program, in behalf of battered women. As previously noted, they also are seeking funds for an on-reservation shelter. Further, they are attempting to develop a core group of Native American women, especially those who have experienced battering, to work within the reservation structure as advocates. The goals of this core group are to raise the overall consciousness of the tribal government to the problem of domestic violence, and to reduce the tribal government's resistance to addressing the problem.

At the Rosebud Reservation, IHS Social Services staff are members of the White Buffalo Calf Women's Society, serve on the Board of Directors for the Family Violence Center, and provide direct services through both IHS and the Center. IHS staff also serve as ongoing resource persons for the provision of mediation and crisis intervention services; and, one staff member is particularly active in community education efforts.

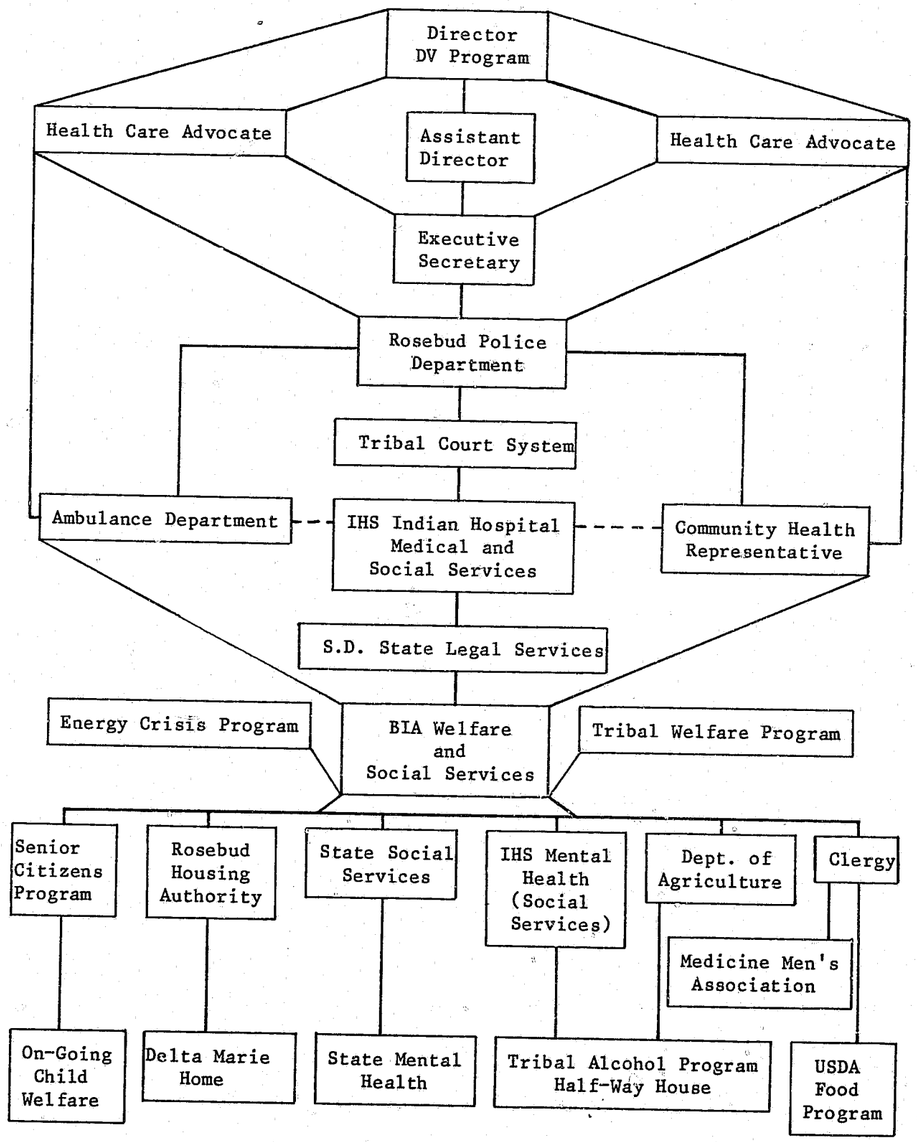
INTER-AGENCY/INTER-PROGRAM LINKAGES

The Fort Apache IHS Social Services staff involved with battered women have established a good referral system with IHS Medicaid staff, and they receive referrals from the medical staff on a regular basis. The IHS staff also have established a working relationship with the nearest shelter, but due to the distance of the shelter, they seldom use it as a referral resource.

The Family Violence Center, on the Rosebud Reservation, has established a comprehensive services network and extensive follow-up procedures in behalf of battered women. (See Exhibit on following page.) The significance of this network is increased by the fact that it is the first of its type on any reservation, and that it can be replicated by all reservations without any additional funds or with a limited amount of funds ($2,000-$3,000).

Representatives from all of the Department/Agencies/programs included on the Exhibit have agreed to be available to the Center at all times to assist with domestic violence intervention activities. The Family Violence Center,

DOMESTIC VIOLENCE REFERRAL NETWORK PROGRAM



for example, has successfully established a client referral and follow-up procedure with the Department of Social Services (DSS) in Mission, South Dakota, twenty miles from the Reservation.

With regard to the DHHS-funded programs selected for study in Todd County (the community which surrounds the Reservation), all interviews were conducted at DSS offices in Mission. (DSS in Mission serves a multi-county area.) Mission, itself, is a very small and isolated, rural community. None of the DHHS-funded programs surveyed provide services specifically targeted on battered women. However, the respondent for Medicaid reported that the program does pay for battered women's medical care when the women are also AFDC or SSI recipients. The respondent for Child Protective Services reported that the program pays for the shelter of battered women's children when the children are also battered or are at-risk of being battered. However, the program cannot pay for shelter for the women.

The Title XX respondent, as well as other program respondents, reported that their staffs rely heavily on the services available through the Family Violence Center. Further, their staffs are always ready to provide victims with transportation services. The respondents are also advocates for State legislation which, if passed, will fund domestic violence program services. However, all respondents also reported that their programs suffer from lack of adequate funding and from categorical program barriers. These factors preclude their ability to be of further assistance to battered women.

SUMMARY

Respondents from IHS, the two Reservations, and from Todd County's Department of Social Services concurred that the problem of domestic violence was very extensive in their communities. Economic and societal conditions, and substance abuse, particularly the abuse of alcohol, were identified by respondents as the basic factors contributing to the problem. All respondents also concurred that their respective States do not recognize domestic violence as a serious problem, that service needs remain basically unmet, and that, in general, services for battered women are either limited or non-existent.

There was particular concern expressed about the fact that the Family Violence Center (on the Rosebud Reservation) may not have sufficient funds to continue its shelter program or to pay Center staff after November 30, 1980. Current Center CETA-funded positions also are being terminated. And, despite the desire of all respondents to have services for battered women and their families generated by the community, all expressed concern about the lack of community-based services and lack of program funding sources.

Finally, according to all IHS Social Services respondents, the situation at the Fort Apache/White River Reservation is indicative of similar conditions on at least 75 to 80 percent of all reservations. In contrast, the activities in behalf of battered women at the Rosebud Reservation are considered the best example of beginning and ongoing tribal grassroots efforts. No other grassroots program is as highly involved in assisting battered women and their families as The White Buffalo Calf Women's Society.

RESOLUTION 80-132 OF THE

ROSEBUD SIOUX TRIBAL COUNCIL

WHEREAS: The Rosebud Sioux Tribe is a federally recognized Indian Tribe organized under the Indian Reorganization Act of 1934 and all pertinent amendments thereof, and

WHEREAS: The Rosebud Sioux Tribe is governed by a Tribal Council made up of elected representatives who act in accordance with the powers granted to it by its constitution and by-laws, and

WHEREAS: The White Buffalo Calf Woman's Society is a legally chartered and incorporated entity as of 1977 for the purpose of dealing with women's role on the reservation and dealing with selected problems which affect women, their children and ultimately the entire family structure and to promote peace, understanding, improving the quality of life for all people on the reservation, and

WHEREAS: The "Society" is greatly concerned with the punishment set forth in the Tribal Law and Order Code for the crime of Assault and Battery has rarely been enforced to the maximum and a majority of these assailants have been dealt with to leniently when compared to the physical and emotional trauma experienced by the victims, and

WHEREAS: The White Buffalo Calf Women's Society has established a Center for Family Violence that has the capability of dealing with this type of behavior.

THEREFORE BE IT RESOLVED: That the Rosebud Sioux Tribe supports the imposition of counselling for both the victim and the assailant as a prt of the sentence for the crime of Assault and Battery through the Family Violence Center for referral to an appropriate agency of their choice.

CERTIFICATION

This is to certify that the above Resolution No. 80-132 was duly passed by the Rosebud Sioux Tribal Council in session July 30, 1980 by a vote of twenty-two (22) in favor none (0) opposed and one (1) not voting. The said Resolution was adopted pursuant to authority vested in the Council. A quorum was present.

Norman G. Wilson
President
Rosebud Sioux Tribe

ATTEST:

Frank LaPointe
Secretary
Rosebud Sioux Tribe

DATE SUBMITTED 8-7-80
TO ROSEBUD AGENCY SUPT.

NOTED AND TRANSMITTED:
GEORGE E. KELLER
Superintendent

THE COMMUNITY MENTAL HEALTH CENTER PROGRAM

AUTHORIZING LEGISLATION

Community Mental Health Centers Act of 1975,
Title III of the Public Health Services Act, as amended

FEDERAL AGENCY RESPONSIBLE

Division of Mental Health Service Programs,
National Institute for Mental Health,
Alcohol, Drug Abuse and Mental Health Administration,
Public Health Service, Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

The Community Mental Health Center program was established to provide comprehensive mental health services to individuals living in a defined geographic (catchment) area. A Community Mental Health Center (CMHC) is either a public or private nonprofit legal entity which must provide services for the mentally ill and emotionally disturbed within the community. There are several Federal grant programs that are used to support CMHCs, including assistance for Planning and Operations, Financial Distress, Facilities, and/or Rape Prevention and Control. These grants are made directly to local CMHCs (except in cases where monies for facilities may be made available to States). However, the State Mental Health Authority must have on file in the DHHS Regional Office an approved mental health services plan before grants can be made.

Within the limits of a CMHC's ability, services must be provided to any individual living or employed in the catchment area, regardless of income. Twelve mental health services must be available through the CMHC or through arrangements with health professionals and others within the catchment area. These services are: inpatient and outpatient services, partial hospitalization, emergency services, consultation and education, services for children and the elderly, screening to courts and other public agencies, referrals to transitional halfway house facilities, follow-up care for those discharged from a mental health facility, and alcohol and drug abuse services (if there is sufficient need).

The Community Mental Health Center program is administered somewhat differently than other DHHS-funded programs in that each CMHC is semiautonomous. All CMHCs have either a Governing Board or an Advisory Board which supervises the administration of direct services; these Boards consist of local service providers and private citizens rather than State officials.

State mental health administrators usually review the CMHCs' grants, funding sources, service contracts, and provider agreements with local vendors and

nonprofit organizations. The local Governing Boards supervise program development, the focus of CMHC activities, and the administration of the CMHCs.

ABSTRACT OF MAJOR PROGRAM FINDINGS

The findings presented in this report are based on data obtained through interviews with State level CMHC administrators and with local CMHC administrators and direct service staff. Forty-one CMHC programs were included in the State Survey. In nine States and the District of Columbia, no State level interviews with CMHC administrators were conducted, either because the State received no applicable Title III funding, or because there were no CMHC program representatives at the State level. Staff of 28 CMHC programs were interviewed for the Community Survey, with 14 of the 15 States participating in the Community Survey represented in this sample. No CMHCs were located in the communities surveyed in the remaining State.

Major program findings are as follows:

- Five percent of the CMHC programs at the State level and 4 percent of the CMHC programs at the community level have definitions of domestic violence.

- At the State level, 27 percent of the programs focus on battered women, 12 percent on battered men, 22 percent on the children of battered women, and 12 percent on abusing spouses. At the community level, 29 percent of the programs focus on battered women, 21 percent on the children of battered women, 14 percent on battered men, and 18 percent on abusing spouses.

- Fifteen percent of the State programs and 32 percent of the community programs have goals oriented toward battered women.

- State CMHC administrators reported no mandated activities on behalf of battered women. At the community level, mandated services and percentage of programs involved include: program funding (7%); collection of statistics (4%); needs assessment (4%); program planning (7%); program monitoring (7%); program evaluation (4%); technical assistance/consultation (11%); staff training (4%); community education (14%); clearinghouse (7%); direct services (7%); coordination activities (11%); and other activities such as legislation, prevention or outreach (7%).

- At the State level, 51 percent of the CMHC respondents reported nonmandated program activities on behalf of battered women. At the community level, 71 percent of the programs are engaged in activities for battered women, either nonmandated or mandated.

- At the State level, 32 percent of the CMHC programs are involved in coordination activities on behalf of battered women. At the community level, 71 percent of the programs participate in coordination activities.

- In 22 percent of the States, some program staff have received training to better understand the needs of battered women and their families, while 71 percent of the community programs have staff who have received this type of training.

- In 37 percent of the States, CMHC respondents identified staff who are advocates for battered women. At the community level, advocates were identified in 75 percent of the programs.

- Seventy-three percent of the State CMHC respondents and 93 percent of community program staff are aware of other advocacy efforts in their States or communities.

- Federal/State barriers to meeting the needs of battered women were identified by 39 percent of the State respondents. Twenty-one percent of the community program respondents reported similar restrictions to serving battered women.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

CMHC's potential to assist abused spouses and their families is discussed in the following sections. These describe the scope of services and activities currently engaged in by CMHC programs to meet the needs of victims, barriers to service delivery identified by respondents, and respondents' recommendations for change.

Specific Program Efforts

CMHCs serve the community as a whole and provide a broad range of services of potential benefit to victims of domestic violence and their families, even though the services are not geared specifically for this population. These services include crisis intervention (occasionally home visits), individual, family, and group counseling, and 24-hour hotlines.

The majority of State (51%) and community (71%) CMHC programs surveyed are engaged in some type of activity for battered women. Direct services to this population are provided by 27 percent of the States and 43 percent of the communities. A few communities have comprehensive domestic violence programs within the CMHC. These programs provide emergency shelter for women and children, counseling, legal aid, transportation, and advocacy. Some CMHCs also have child day care, vocational counseling, and programs for abusing spouses. One CMHC funds a spouse abuse center that serves women from ten surrounding catchment areas. Several programs offer vocational life skills training for women and provide staff to serve as advocates and witnesses in support of battered women in court.

A number of CMHCs also are engaged in other activities on behalf of victims, such as training of police officers and community education on the legal rights of women. One CMHC is conducting research on the relationship between family violence and substance abuse.

Some CMHC respondents identified unique or innovative activities assumed by their programs. For example, one CMHC engages in outreach activities to identify victims of domestic violence, especially in rural areas. A variety of demonstration projects to assist abused spouses were reported by respondents. One project is involved in a study of specific aspects of family violence (e.g., alternatives to incarceration of abusers) and the implementation of unique treatment approaches in conjunction with law enforcement agencies, substance abuse treatment programs, and other community resources.

In one community, the administrator of the CMHC has a policy that staff members must choose a particular area of interest on which to focus their efforts. Several staff members are selecting assistance to domestic violence victims and their families as the targeted activity area; thus, special programs and services are being developed for battered women. In another community, staff concern about the lack of services to battered women prompted the CMHC director to seek special funding from the State for therapeutic support groups for both battered women and abusing spouses. Another community has a staff person designated as a domestic violence specialist; she works full time on this problem area and provides direct services for victims. In some States, the administrative policy is to allow each catchment area to choose special services on which to focus; many select women's services with specific emphasis on domestic violence, rape, assertiveness training, and/or life skills training.

Most of the CMHCs surveyed do not have statistics on the number of victims served by their programs. Staff from one CMHC, located in a metropolitan area, estimated that they served 300 battered women in the past year. Estimates from other CMHCs range from a few cases a year to as high as 40 percent of the total caseload.

In approximately 65 percent of the communities, CMHC respondents said that program intake procedures include probes for the identification of abused spouses. In these programs, respondents reported that marital problems, alcohol abuse by the spouse, and unemployment are the most common problems presented by battered women.

Respondents from nine of the 28 local CMHCs surveyed provided information on the service strategies employed when working with domestic violence victims. Eight of these programs offer therapeutic intervention with the abuser while the other program is oriented toward court intervention. Four of the programs focus on the immediate safety of the victim through provision of emergency shelter care, two focus on safe reconciliation of the situation within the home, the other three programs use both strategies. A traditional social service model, rather than the self-help model, is used by seven of these CMHCs.

As mentioned previously, 32 percent of the State CMHC administrators and 71 percent of the local CMHC staff reported involvement in coordination activities focused on domestic violence victims. The most frequent linkages established by CMHCs are with other departments or programs within the social services network. These include family services, child welfare, child protective services, adult protective services, Aid to Families with Dependent Children (AFDC), substance abuse treatment programs, and health services.

Many CMHCs, however, have gone beyond these programs to develop reciprocal relationships with other types of community agencies. For example, some shelter programs, which provide crisis and support services to battered women, work closely with CMHCs in developing counseling approaches, referral mechanisms, and complementary services. Some CMHCs have coordinated with law enforcement agencies to develop police training programs. Other CMHCs coordinate with the judicial system, particularly the family courts, legal aid services, and attorneys interested in victim-witness programs, advocacy, and lobbying activities.

CMHCs also have developed relationships with task forces, coalitions, and women's organizations to advocate and lobby for legislation on behalf of battered women, conduct needs assessments, and collect statistics on the incidence of domestic violence. Other linkages established by CMHCs include those with Departments of Education to develop prevention and community education programs, with colleges and universities studying the problem of domestic violence, with State hospitals and medical examiner's offices, and with day care providers.

Reportedly, staff advocacy efforts have resulted in increased public awareness about the problem of domestic violence and in encouraging abused spouses to seek services through CMHCs. Staff advocacy activities have included writing letters of support for shelters, public speaking, participation in meetings with task forces and other agencies concerned about the problem, and volunteer work at shelters.

Barriers to Service Delivery

Several types of barriers are perceived by CMHC respondents as limiting their programs' capacity to meet the needs of victims. In 39 percent of the States and 21 percent of the communities, respondents identified barriers related to Federal/State regulations and policies. With regard to eligibility requirements, the major reason why battered woman may be denied service through a CMHC is because she lives outside the catchment area, or in some programs, because she does not meet the criteria of being "mentally ill." Conversely, the Federal mandate to serve anyone in a catchment area results in large caseloads and the dilution of staff and services over many diverse problem areas. The requirement for local matching funds presents another barrier. Some communities cannot obtain available Federal CMHC funds because of their inability to raise matching funds. Restrictions in other programs also limit reimbursement for services which CMHC programs could provide to battered women. For example, use of Title XX funds for psychiatric services typically requires a diagnosis of mental illness. Interpretation of the language in the Title XIX enabling legislation results in the requirement that a physician be on staff and authorize services delivered to clients in order for the CMHC to qualify for Title XIX reimbursement.

Some respondents believe that the lack of a mandate to serve battered women constitutes a barrier to providing services. However, at least one State's regulations do not allow the targeting of a special population such as battered women. In another State, the reimbursement policy is based on hours or units of service rather than on problem areas.

Respondents also identified other barriers. In some CMHCs, staff reported that they cannot take on additional work and/or lack the knowledge and expertise to work with domestic violence victims. Other problems cited by respondents include: the difficulty in identifying battering when it is not the client's presenting problem; language barriers, especially in communities with recently arrived refugees; the amount of time required for paperwork and recordkeeping; and fees based on family income.

Factors that hinder coordination efforts also were identified. The issue of confidentiality was mentioned frequently. CMHC staff find their efforts to coordinate with substance abuse treatment programs and child protective services curtailed by these agencies' reporting requirements. Because CMHC clients are assured confidentiality (through Federal legislation and regulations), program staff are hesitant to share information with other agencies.

Program Recommendations to Enhance Service Delivery

Some of the recommendations made by CMHC respondents relate to achieving better coordination of services on behalf of victims. Several respondents expressed the need for a domestic violence service resource directory. Others believe there is a need for more interagency activities, such as staff training, conferences, crisis intervention teams, and needs assessments.

Respondents often mentioned the need for additional funds to target on abused spouses. One respondent suggested freeing up CMHC funds by changing Medicaid regulations so that Medicaid, rather than CMHC funds, could be used for services for the deinstitutionalized mentally ill. The need for specialized staff and for staff training in identifying high risk clients and in understanding the dynamics of domestic violence also was noted by respondents.

Although many barriers and restrictions were identified, very few respondents knew of any attempts to resolve these problems. One State, however, is attempting to standardize the matching formulas for mental health, mental retardation, and alcohol and drug programs.

The need for more staff training was mentioned repeatedly by respondents throughout both State and community interviews. Specific requests for training include:

- The dynamics of spousal abuse and the extent of the problem.
- Effective treatment strategies and techniques for detection, intervention, and prevention.
- Methods to motivate battered women and abusing spouses to seek help.
- Methods to educate the public about the problem, increase the sensitivity of the courts, and gain community support.
- Attitudinal/sensitivity training.

- Availability of and access to domestic violence service providers and funding sources.
- Information on domestic violence legislation and legal issues.

SUMMARY

The CMHC program does respond in a number of ways to the needs of abused spouses and their families. In over one-half of the program's surveyed at the State administrative level and nearly three-fourths of the programs surveyed at the local level, staff are involved in some kind of activity directed toward the problem of domestic violence. Many respondents believe services for victims are an appropriate function of CMHCs; however, they also note that expansion in this area is limited by funding and staffing constraints and by the lack of a Federal or State mandate to serve victims and their families as a special subpopulation.

ALCOHOL FORMULA GRANTS AND

ALCOHOLISM TREATMENT AND REHABILITATION PROGRAMS

AUTHORIZING LEGISLATION

Title III-A and III-B (respectively), Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended

FEDERAL AGENCY RESPONSIBLE

National Institute of Alcohol Abuse and Alcoholism (NIAAA); Alcohol, Drug Abuse and Mental Health Administration; Public Health Service; Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

The Alcohol Formula Grants Program enables States to develop and implement comprehensive and statewide alcoholism programs. Emphasis is on moving the treatment of alcoholism and alcohol abuse into the mainstream of health and social services. Grants are made to Single State Agencies responsible for developing and carrying out the State alcoholism plan. The Single State Agency, in turn, distributes funds to local agencies and organizations.

The Alcoholism Treatment and Rehabilitation Program enables States to provide quality alcohol abuse and treatment services to all persons in need of them, coordinate services within the broader context of accessible and available community resources, and expand involvement of public agencies (e.g., law enforcement, schools, health agencies) in arranging for and/or providing alcohol treatment services. Alcoholism Treatment and Rehabilitation grants are disbursed by NIAAA to public or private non-profit organizations, including State and local governments. The program's service delivery system is locally-based and is usually administered by community mental health centers, community health centers, public health departments or private agencies.

Program activities include preventive educational efforts, research on alcohol abuse and its diagnosis and treatment, and specific treatment components aimed at identifying and treating alcohol abuse within special population groups. For purposes of this study, it is significant to note that one population group sometimes targeted by Alcoholism Treatment and Rehabilitation programs is women. Further, victims of alcohol related domestic violence are specifically included as a target population in the authorizing legislation of NIAMA.

ABSTRACT OF MAJOR PROGRAM FINDINGS

The data presented in this abstract are based on interviews conducted with State-level alcohol program administrators in 50 States and with local alcohol program administrators and direct service staff in 29 communities. These two numbers (50 and 29) are the bases for the respective State and community percentages presented throughout this discussion, unless otherwise noted. No distinction is made between the programs surveyed on the basis of the Federal funding services described in the Program Overview. Major program findings are as follows.

- In 18 percent of the States and in seven percent of the communities, alcohol programs have definitions of domestic violence.
- In slightly less than one-third (30%) of the States and in 10 percent of the communities, alcohol programs focus specifically on battered women, children of battered women, battered men, and/or abusing spouses.
- In 26 percent of the States and in ten percent of the communities, alcohol programs have goals or objectives which address the needs of battered women.
- In only one State does the alcohol program have mandated responsibilities on behalf of battered women; however, in 58 percent of the States and in 38 percent of the communities, alcohol programs have undertaken some activities for battered women, even though not mandated to do so.
- Coordination activities with other programs or groups on behalf of battered women have been assumed by alcohol programs in 56 percent of the States and in 38 percent of the communities.
- In 38 percent of the States and 45 percent of the communities, program staff have received some training and/or technical assistance to better understand the needs of battered women and their families.
- In 68 percent of the States and 55 percent of the communities, one or more program staff have promoted assistance for battered women.
- In 82 percent of the States and 86 percent of the communities, respondents are aware of other programs, grassroots organizations, or advocacy groups which focus activities on behalf of battered women.
- In 48 percent of the States and 38 percent of the communities, respondents identified Federal or State restrictions which affect their programs' capacity to address the needs of battered women.

In the following sections of this program analysis, these and other findings are discussed in greater detail.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

To assess the alcohol program's potential to assist battered women and their families, the following sections describe specific program activities related to domestic violence and the scope of those activities, barriers to service delivery identified by program respondents, and program recommendations from respondents for facilitating the delivery of services to battered women.

Specific Program Efforts

Both the State and the Community Surveys include questions about program efforts which focus on battered women, their children, battered men, and/or abusing spouses. In 24 percent of the States and in 10 percent of the communities, alcohol programs are focusing activities on battered women. Ten percent of the State programs have a focus on the children of battered women, as do 10 percent of the community programs. Two State programs (4%) and one community program focus on battered men. The abusing spouse is focused upon by four States (8%) and three communities (10%).

Nine State programs (18%) and two community programs (7%) have formulated or adopted definitions of domestic violence. Definitions range from the very broad, including all victims of violence, to the very specific, delineating certain types of physical and/or emotional abuse or threat of abuse, conditions of residence under which abuse must occur, and the relationship or former relationship of the persons involved. None of the respondents surveyed believe that the definitions limit the program's ability to serve battered women.

Twenty-six percent of the State programs and ten percent of the community programs surveyed have established goals and objectives specific to battered women. Program objectives identified by respondents include: encouragement (or requirement) of wives to participate in the alcohol treatment of their spouses; provision of services to battered women as part of a network of activities focused on women's needs; development of prevention and outreach models directed at domestic violence victims and other special populations; establishment of domestic violence identification, screening, and referral mechanisms; emphasis on the family intervention treatment approach; and the provision of training on domestic violence to local program staff. Further, in several States, alcohol programs have established the objective to research and describe the relationship between alcohol abuse and domestic violence.

Thirteen local programs, representing 45 percent of the communities surveyed, have intake and assessment procedures which attempt to identify battered women. Respondents from these 13 programs were asked about the types of problems battered women present at the time they apply for help. Marital problems, emotional abuse by the spouse, and alcohol abuse by the spouse were identified most frequently.

Alcohol programs in 58 percent of the States and 38 percent of the communities have some activities for battered women. The most common activity is program coordination (in 56% of the States and 38% of the communities). Other discrete activities of State and community alcohol programs on behalf of battered women include staff training (30% of the States), technical assistance

and consulation (28% of the States), needs assessment and collection of statistics on the problem (14% and 17% of the communities respectively). Direct services are provided to battered women in ten States and three of the communities surveyed.

In two of the community programs providing direct services to battered women, respondents provided information about various aspects of service delivery. There was some variation reported in the service strategies of the two programs. Both programs use professional as opposed to lay staff; one is involved primarily in crisis intervention services while the other offers ongoing treatment services; one is oriented toward provision of shelter care for the victim while the other is oriented toward reconciliation of the situation within the home; one uses therapeutic intervention with the abuser, and the other uses both therapeutic and court intervention, depending on the individual circumstances; and finally, one program uses a self-help or peer support model, while the other supplements the self-help model with a traditional social services model.

A closer examination of alcohol program activities on behalf of battered women at the State level reflects some innovative planning and coordination efforts. For example, in one State, a training program links alcohol treatment staff to child abuse, social welfare, and mental health teams to increase effective, coordinated, and prompt service delivery to battered women. In another State, legislation passed in 1976 mandates that an Interdepartmental Council meet regularly to coordinate services, including services to victims of domestic violence. Members of this council include representatives of the alcohol and drug program, law enforcement agencies, and the Departments of Corrections, Transportation, Children and Family Services, Public Aid, Public Health, and Education. Another State alcohol program obtained a grant to place in the District Attorney's office an attorney who handles only domestic violence cases.

At the community level, several innovative activities for battered women were identified by alcohol progam respondents. In one community, the drug, alcohol, and spouse abuse treatment facilities are housed together to facilitate services. In another community, the alcohol program has a special service component for second-time alcohol offenders who are referred by the court for a mandatory two-week program. Since services provided by this special program focus on family and group counseling, battered women often are identified and, in turn, receive comprehensive assistance.

In another community, the alcohol program functions as an intake and dispersal center for many smaller agencies. When battered women are identified, they are directed to the various community agencies which can best meet their needs. The program's intent is to find appropriate help for battered women quickly and efficiently.

In another community, male counselors from various service agencies, including the alcohol program, have formed a group called "Male Counselors Against Battering Syndrome." The purposes of this group are to increase the counselors' sensitivity to domestic violence and to the battered women they serve and to help develop techniques to reduce the barriers they may encounter

as counselors in treating battered women, for example, women's fear of males, or their perceptions that males cannot be empathic and helpful. In another community, the substance abuse program is the parent organization of a domestic violence shelter program. This arrangement resulted from a decision to try to reach male alcoholics through their wives. After a female outreach worker started a counseling support group for the wives of alcoholics, she discovered that all group participants were battered women. The alcohol program then developed the shelter program and obtained CETA funding to hire several of the battered women from the support group as the shelter's first staff. According to respondents, the support group continues to be very successful in identifying battered women, in serving them, and in addressing the issue of domestic violence in relationship to alcohol abuse.

Respondents in many States and communites indicated that it is feasible for their programs to assume (additional) activities on behalf of battered women. At the State level, respondents frequently suggested coordination with other agencies and programs, direct services, and community education. At the community level, respondents identified community education, staff training, and direct services. In discussing the possibility of providing direct services to battered women, some program respondents cautioned that such an effort could be made "only if we get the money and staff required" or "if the rules are changed to allow work with family members of alcohol abusers."

Since nearly all of the State and community programs which have undertaken some kind of activity on behalf of battered women are involved in coordination activities (56% and 38%), the types of coordination activities warrant closer examination. Thirty percent of the States and 10 percent of the communities are involved in domestic violence task forces or committees. In 24 percent of the communities and 12 percent of the States, coordinatic activity is formalized as a service agreement. Other forms of coordination performed by alcohol programs on behalf of domestic violence victims include informal meetings with other program staff (28% of the States and 24% of the communities) and sharing of staff (18% of the States and 21% of the communities). Finally, other coordination activities (referrals, sharing of information, joint planning, joint lobbying) were identified by 18 percent of the States and seven percent of the communities. The following examples illustrate the purposes of these coordination efforts.

Among State programs, coordination activities identified include: joint research projects with colleges and universities; the development of identification procedures and referral mechanisms for victims with other State agencies (e.g., mental health, family services, adult and child protective services, and child welfare services); clarification of procedures related to issues of confidentiality and privacy of information versus mandatory reporting of physical abuse; and cooperative funding with vocational rehabilitation divisions of halfway houses offering transitional services. With local agencies, State programs have been involved in: promoting service delivery to battered women through addiction treatment facilities, counseling centers, shelters, and halfway houses; providing consultation and technical assistance to various service providers; and outreach and prevention activities. In addition, some States work with local criminal justice systems to conduct training courses, workshops, and prevention activities on domestic violence. The number and type of

coordination activities vary according to geographic area, extent of activity focused on domestic violence, and the degree to which service needs are recognized at the State level; thus, not every State has developed comprehensive coordination networks.

Among community programs, linkages were identified with other local programs such as shelters, Women's Aid, hospitals, mental health centers, coalition task forces, and advocacy groups. As noted earlier, in one community, the alcohol treatment facility is housed with the drug treatment facility and the spouse abuse center; thus, battered women and their families can more easily receive a range of services for several different problem areas. In those communities where coordination activities have not been established on behalf of battered women, alcohol treatment program staff generally agreed that their primary concern is with the medical detoxification and treatment of alcoholics.

In the 13 community programs where some type of intake or assessment procedures are used to identify cases of battering, program staff were asked to identify the other providers to which battered women are referred. Twelve of the 13 programs refer battered women to social services agencies and service providers dealing especially with victims. Well over 50 percent of these 13 programs also refer these women to providers of health, employment, legal/court, mental health, housing and alcohol and/or drug treatment services. Once these referrals are made, program staff engage in activities which include: follow-up contact with the battered woman at specified time intervals; information sharing and/or a joint case planning meeting with the other provider; staff monitoring of the services given by the other provider; case transfer to the other provider; and case closing on the part of the alcohol program. Thus, continued liaison with either the client or the provider is facilitated in a number of ways once the referral is made.

With regard to advocacy group efforts, State program respondents believe the accomplishments of these groups lie primarily in identifying and working for legislative changes, increasing public awareness, and obtaining funding and providing services for battered women. At the community level, respondents generally spoke positively about advocacy group efforts, particularly efforts to promote community education, shelter care and crisis intervention.

Barriers to Service Delivery

State and community program respondents identified barriers to providing services to domestic violence victims. The initial discussions in this section describe the extent to which respondents perceive that these barriers derive from Federal, State and programmatic restrictions. In successive paragraphs, other inhibiting aspects to service delivery are cited, based on respondents' comments. These comments may help to explain why battered women are reluctant to request services, why they may be considered ineligible for services, and why programs cannot presently assume any (additional) activities for battered women.

- Federal Legislation and Regulations

In theory, treatment provided by alcohol programs is to be directed to individuals whose primary problem is alcohol abuse and to their families. In practice, funding constraints limit delivery of services to those persons who are alcohol abusers. Family members who are not alcohol dependent, referred to as collaterals, typically do not receive services. In those instances in which programs do offer assistance to family members of alcohol abusers, the alcohol abuser must be in treatment. Thus, the battered spouse of an alcohol abuser who refuses treatment cannot obtain program services. Further, reimbursement for services delivered to collaterals was reported as being very difficult to obtain. In fact, most respondents who discussed this issue indicated that services provided to collaterals are not reimbursable.

Another restriction pertains to the confidentiality of client records; two conflicts were perceived by respondents. One conflict pertains to the requirement that consent of the client must be obtained in order to release records or information contained therein to other agencies. Thus, referrals to other service providers, or intervention in the family situation, are not possible in many cases without violation of the law. Akin to this aspect is the requirement in some States that physical abuse of an adult be reported. Respondents expressed concern about the dilemma posed in guaranteeing client confidentiality while simultaneously being aware of situations which jeopardize the safety and/or well-being of family members. These conflicts can result in reprisals against program staff in the absence of clear legal requirements which resolve how to handle situations of domestic violence.*

- Federal and State Resources: Monetary, Facilities, Personnel

This year the funding levels for Alcohol Formula Grants to States were decreased markedly. Approximately six million dollars were cut from this Federal budget item, and similar reductions occurred in the funding of the Alcoholism Treatment and Rehabilitation Program. For example, one State's budgets for Fiscal Years 1981 and 1982 are affected by a 44 percent cutback in Federal funds.

Several other major concerns were articulated by program respondents with respect to serving battered women. The first concern relates to the lack of inpatient treatment facilities for women, battered or not. Since there is a

*The reader is referred to Part 2 of Title 42 of the Code of Federal Regulations, published July 1, 1975, for clarification on the issue of confidentiality of alcohol and drug abuse patient records. The regulations amplify provisions authorized under Section 333 of PL 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and amendments. There is also information available about qualified service organization agreements which may be useful in clarifying the perceived restrictions of the confidentiality regulations for domestic violence providers (page 31 of "Alcohol Health and Research World, Fall 1979").

prohibition against funding of combined treatment facilities for both men and women, most programs operate facilities for males.* Combined with an emphasis on outpatient services for male clients, women frequently may be underserved within the range of available program services. Concomitant with this problem, many women are in need of child care in order to participate in treatment. The lack of child care facilities and/or a mechanism or authorization to purchase child care services reduces the opportunity for women with alcohol problems who otherwise might seek comprehensive treatment.

Second, many alcohol programs have insufficient numbers of staff to provide services to families of alcoholics and abusive spouses. Furthermore, some respondents spoke of the lack of staff capability to deal with women who are alcohol abusers, let alone battered women who may or may not be problem drinkers. Finally, the rural populations may experience difficulties in gaining access to services.

- State Regulations, Policy, and Administrative Structures

Some States limit alcohol treatment services to those who are alcohol dependent. If, in addition, no direct services can be purchased for non-alcoholic family members, victims of abusive spouses are excluded from any services except information and possibly referral.

Two disparate issues pertaining to administrative structures were highlighted by State program administrators. The first relates to those States which have a State-funded domestic violence program or which have delegated responsibility for aiding domestic violence victims to a particular agency, e.g., the Department of Social Services. The existence of a specially designated program seems to promote the belief that alcohol program staff do not have the authority, funds, staff, or support necessary to also deliver services to battered women.

The second issue deals with those alcohol treatment programs administered through the Community Mental Health Center (CMHC) program. In some instances, although the two programs are organized as separate divisions, compliance with CMHC policies, priorities, and mandates is required of the alcohol program. The latter cannot establish independent service contracts or provider agreements or undertake separate program development. This constraint may limit alcohol treatment program efforts targeted on domestic violence victims.

- Programmatic Issues

Several programmatic restrictions perceived by respondents tend to overlap into other areas previously discussed: the prohibition against funding combined male/female inpatient treatment facilities; the orientation toward treating males, with few facilities and services focused on women; the

*At the Federal level, there is no prohibition against NIAAA funding of combined treatment facilities for both men and women. This respondent perception appears to be based on misinformation or on State policies and regulations that deter combined treatment facilities.

restriction against reimbursement for services delivered to collaterals; the lack of child care services for women interested in seeking treatment; and a lack of expertise and awareness about women who are alcohol abusers themselves and/or battered.

Respondents in two community alcohol programs providing direct services to battered women identified specific population groups who are not seeking assistance from alcohol programs. Middle class victims are perceived as having other resources for assistance, Vietnamese women as experiencing cultural barriers against seeking services, and Native American women as having limited access to services because of tribal autonomy on the reservation.

Some program respondents believe it is not feasible for their program to assume activities on behalf of battered women. Among State program respondents, comments tended to focus on the inability and/or inappropriateness of the alcohol program to provide direct services to battered women. At the community levels, respondents amplified these themes by citing funding restrictions, lack of staff and facilities, and higher priorities based on other problems frequently presented by their clientele.

In addition to problems related to inadequate resources, articulated by 79% of the community program respondents, they cited additudinal barriers. On the one hand, the problem of domestic violence is regarded as a private matter; on the other hand, there is such a stigma attached to the problem that victims tend to keep it hidden.

In summary, the primary barrier to serving battered women in an alcohol program setting is that, in most communities, services are limited to clients who are alcohol dependent; if the woman does not have an alcohol problem herself, she is not eligible for services. In some cases, programs do provide services to relatives of the alcohol dependent person, but this practice is not uniform.

Program Recommendations to Enhance Service Delivery

This third section of the program analysis presents information on ways alcohol programs' service delivery to battered women can be enhanced, based on recommendations offered by the program respondents surveyed. These recommendations relate to steps which could be taken to better coordinate activities, specific program changes, suggestions made by battered women encountered in the programs' client population, and recommendations for training and technical assistance.

Respondents indicating that their programs are involved in some coordination activities were asked to identify steps which can be taken to better coordinate programs for battered women. At both the State and community levels one recurrent theme is the need for developing a network of interagency (and domestic violence) service providers. To develop such a network might involve the identification of populations eligible for assistance and the services available through each program, clarification of the roles of social service agencies and the legal system, staff training and involvement in public education and awareness efforts. Some respondents felt that a single State coordinating

agency or body is required to implement such an interagency effort. Others believed that a mandate or priority to better serve battered women must precede any major coordination effort.

Several program changes were suggested to better serve battered women. Several State administrators suggested that legislative or regulatory changes be made to permit reimbursement for collateral services. A number of State and community respondents believe that staff training is a necessity, in order to identify battered women during intake, to increase staff sensitivity, and to provide specialized and effective treatment strategies. Additional resources, in the form of facilites, staff, and money, were mentioned frequently, especially by community respondents. Finally, a "campaign" for developing public information and education activities, to include identification of existing resources and outreach, was cited repeatedly by local program staff.

Several efforts are reportedly underway which may positively affect programs' ability at the local level to serve battered women. These include the establishment of new shelter facilities in several communities, the availability through social services of emergency funds for lodging, an Indian Health Services hospital which is planning an inpatient treatment facility for women, and the pending application of one program for an NIAAA grant to provide services and coordinate with other programs.

Several State program respondents identified legislative activities which may enhance their program's abilities to serve battered women. In two States, bills which require that health insurance carriers include coverage for family members when one is alcohol or drug dependent have been considered recently. One bill was passed (the other was defeated). In a third State, a Domestic Violence Services Act, which would provide money for programs, is pending. In another State, a pending comprehensive mental health bill will give authority to the Alcohol and Drug Abuse Division to act on behalf of victims. Upon the identification of battered women, other agencies will refer victims to the Division's local alcohol and drug treatment programs, which then will assume primary responsibility for service provision.

All program staff were asked if the battered women they have encountered have made any suggestions about how service providers in the community can be more responsive to their needs. Among those respondents who answered affirmatively and gave suggestions, a variety of direct service needs are revealed: shelter, day care, services and protection for children, job training and employment, free counseling, peer groups, treatment for abusers, better referrals by police, and a service provider network with line staff who know one another.

Several types of training and technical assistance were suggested to increase program staff's ability to meet the needs of battered women and their families:

- Information from other service providers or programs (national, State or local), experienced in working with battered woman, about planning and developing a program and programmatic approaches that work.

- Understanding of the dynamics of domestic violence.
- Specific treatment strategies and clinical training to assist battered women effectively.
- Methods of treatment developed among interdisciplinary providers.
- Relationship between substance abuse and domestic violence.
- Sensitivity training and interview techniques to help identify battering and assist victims in getting needed services.
- Data on the incidence and prevalence of domestic violence.
- Identification of existing resources, including available literature and expert trainers.
- Legal perspectives on the problem and permissible intervention procedures.

SUMMARY

In most of the alcohol treatment programs surveyed, adult, alcohol dependent males are the primary client population served. Less than one-half of the community programs serve women. When this treatment is provided, it is through separate treatment facilities for alcoholic women or through counseling and support groups for women with alcoholic family members. Services available through the alcohol program focus primarily on medical and psychological treatment approaches to alcohol addiction.

Data presented in the preceding sections reveal that:

- Relatively few States (20%) and communities (10%) in the samples offer direct services to battered women.
- More State than community alcohol programs (58% vs. 38%) reported activities on behalf of battered women.
- Inadequate community resources is the most frequently mentioned overall barrier to victims being served by alcohol programs.
- Some program respondents at both the State and community levels questioned the appropriateness of trying to serve battered women through their program; in addition, other problems appearing among their existing clientele have higher priority, especially in the face of increasingly limited resources.
- Among the activities respondents feel it is feasible for their program to assume on behalf of battered women are coordination activities, community education, and staff training.

- Recurrent themes for enhancing service delivery to battered women are the establishment of an interagency provider network, establishment of a mandate or priority to better serve battered women, staff training, and a regulatory change to permit reimbursement for collateral services.

The alcohol program seemingly has great potential to serve abused spouses and their families because of its exposure to the problem of domestic violence among the client population presently served and the types of staff and services available. There appears, however, to be a need for clarification among many respondents on Federal regulations concerning confidentiality of records, the use of combined residential treatment facilities for men and women, and the use of NIAAA funding for services to family members of alcohol abusers.

DRUG ABUSE DEMONSTRATION AND COMMUNITY SERVICE PROGRAMS

AUTHORIZING LEGISLATION

Section 410, Drug Abuse Office and Treatment Act of 1972, as amended

FEDERAL AGENCY RESPONSIBLE

National Institute on Drug Abuse (NIDA),
Alcohol, Drug Abuse and Mental Health Administration (ADAMHA),
Public Health Service, Department of Health and Human Services (DHHS)

PROGRAM OVERVIEW

Drug Abuse Community Service Programs provide funds to partially support the operational costs of community-based treatment programs which reach, treat, and rehabilitate narcotic addicts, drug abusers, and drug dependent persons. Funds are made available, on a competitive basis to specific local projects, under a diminishing grant system for an initial period of three years. However, all treatment monies are channeled through the Single State Agency (SSA) responsible for statewide planning, administration, and coordination of drug abuse programs.

Drug Abuse Demonstration Programs cover the operational costs of programs which: 1) evaluate the need for and adequacy of treatment for narcotic addiction and drug abuse or 2) are determined to be of special significance because they demonstrate new and effective methods of service delivery. Demonstration programs are fully funded for a three-year period. Funds may be channeled through the Single State Agency or may be given directly to projects considered to be research efforts. Individuals eligible to receive services through Drug Abuse Demonstration and Community Service Programs include narcotic addicts, drug abusers, and drug dependent persons. Family members also may receive those supportive services which are within the scope of a specific program's activities. In most cases, the clientele consists of adults (over age 17) with a drug abuse problem, usually with a prior history of addiction, and with no other chronic or severe physical or mental illnesses.

Drug Abuse Community Service Programs may provide detoxification and institutional and/or community-based aftercare services. Funds from the Drug Abuse Demonstration Programs may be used for treatment and rehabilitative services for employees; vocational rehabilitation services; establishment and evaluation of treatment programs within criminal justice systems; determination of causes of drug abuse in a particular area and prescription of methods for alleviating drug abuse; improvement of drug maintenance techniques; and evaluation of treatment programs.

ABSTRACT OF MAJOR PROGRAM FINDINGS

Interviews were conducted with drug program administrators in 49 States. In addition, administrators and direct service staff in 29 community drug programs were interviewed. The findings presented in this report are based on the respective numbers in each data base (49 and 29), unless otherwise noted. Major program findings include the following:

- In 12 percent of the States and 10 percent of the communities, drug programs have established or adopted a definition of domestic violence.
- In 31 percent of the States and 14 percent of the communities, drug programs are focusing some program efforts on battered women, children of battered women, battered men, and/or abusing spouses.
- In 20 percent of the States and 14 percent of the communities, drug programs have goals or objectives which specifically address battered women.
- No programs have any mandated responsibilities on behalf of battered women; however, in 59 percent of the States and 55 percent of the communities, drug programs have undertaken activities directed toward this population. Most frequently, these activities involve coordination with other programs in behalf of battered women (49% of the States and 55% of the communities).
- In 43 percent of the States and 48 percent of the communities drug program staff have received training and/or technical assistance to better understand the needs of battered women and their families.
- In 55 percent of the States and 45 percent of the communities, one or more program staff were identified as advocates for battered women.
- Restrictions affecting the drug programs' capacity to address the needs of battered women were identified in 61 percent of the States and 55 percent of the communities.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

In examining the potential of drug abuse treatment programs' potential to assist abused spouses and their families, this section discusses the types and scope of program activities related to domestic violence, specifically battered women; barriers to service delivery identified by program respondents; and recommendations from program respondents for enhancing service delivery to battered women.

Specific Program Efforts

In 31 percent of the States and 14 percent of the communities, drug programs focus some type of effort on victims of domestic violence. Most of

these programs focus on battered women (22% of the States and 10% of the communities).

Only a few State (12%) and community programs (10%) have formulated or adopted definitions of domestic violence. The definitions range from the very broad, which include men, women, children, and the elderly, to the very specific, which delineate types of physical and/or emotional abuse or threat of abuse, conditions of residence under which abuse must occur, and the relationship or former relationship of the persons involved. In a larger proportion of the States and communities (20% and 14%, respectively), drug programs have developed goals or objectives which specifically address battered women. In some programs, the goals were formulated in response to State directives, resulting from the research and advocacy efforts of Governors' Advisory Councils, Women's Task Forces, and Coalitions Against Domestic Violence. These groups examined the special service needs of women, the relationship of substance abuse to family violence, and then identified funding sources for special programs. Respondents reported that, in recent years, their programs' State plans and budget requests are more concerned with battered women as a group because of advocacy group efforts.

Fifteen of the 29 community programs (52%) surveyed attempt to identify battered women through their intake and assessment procedures. When queried about the types of problems presented by these victims, respondents, in approximately three-quarters of these programs, said that social isolation, marital problems, and emotional abuse are the most common problems experienced by victims.

To help address the needs of battered women, programs in nearly three-fifths of the States (59%) and in over one-half the communities (55%) have undertaken activities directed toward this population, even though not mandated to do so. Coordination with other programs or organizations occurs frequently in both the States (49%) and communities (55%). In 36 percent of the States, drug programs are involved in program planning and/or monitoring of efforts in behalf of battered women. From 20 to 27 percent of the States also have responsibilities for program funding, needs assessment, technical assistance and consultation, direct services, staff training, and community education related to battered women. Apart from coordination activities, the most common responsibilities assumed in behalf of battered women at the community level are the collection of statistics (21%), staff training (24%), and direct service (24%).

In some programs, special counseling and crisis care programs for battered women who are also substance abusers have been developed, as have activities specifically aimed at helping battered women whose spouses are drug-addicted. Needs assessment and intake procedures to better identify battered women are promoted in some programs. Other programs have arranged service contracts with Community Mental Health Centers for direct treatment of substance abusers who are also domestic violence victims.

Through the receipt of NIDA monies, drug programs have increasingly become involved in the funding and operation of shelters and halfway houses for substance-abusing, battered women and their children. In other communities,

training of drug program staff and other program staff (e.g., law enforcement officers) has focused on family violence and substance abuse. For example, in one State, drug program staff provided information and training on drug abuse to staff from a "safe house;" the "safe house" staff, in turn, provided training on domestic violence for drug program staff.

NIDA funds support "women in transition" programs, media campaigns on domestic violence and substance abuse, clearinghouse information, prevention, and the provision of technical assistance to other service providers. State drug program respondents also indicated some of their staff have participated in the National Drug Abuse Training Institute's "Women in Treatment" course, which contains a component on battering and rape.

Several unique features within drug treatment programs enhance service delivery efforts in behalf of battered women. In one State, a direct focus on domestic violence has existed since 1979 through a network of State budget planning committees, which allocates funds for substance abuse programs. In another State, a legislatively mandated Interdepartmental Council, consisting of Drug and Alcohol Treatment programs, Law Enforcement Agencies, and Departments of Corrections, Transportation, Children and Family Services, Public Aid, Public Health, and Education, meets regularly to coordinate service delivery and establish referral procedures. At a large university, the methadone program for drug abusers has a special family violence unit that requires participants to attend three counseling sessions per week. In one community surveyed, a drug treatment program, an alcohol treatment program, and a spouse abuse center are all housed in the same facility. These three programs serve the population of a seven-county area and provide education, referral, treatment, and support both to women with substance abuse problems and to battered women.

Another service delivery model identified by the survey is a community drug program which functions as an intake and client evaluation center for several smaller programs. As clients are screened, their service needs and presenting problems are carefully identified. Subsequently, each client is directed to the appropriate program(s) or resource(s). Another drug program has developed a special treatment component for women, where battered women are counseled specifically on domestic violence issues and helped to find alternatives to their current living situations. Referrals are made to local shelters, job counseling programs, and legal services. This program reported that one-third to one-half of its caseload of women is battered. Finally, one local drug council funds a VISTA position for a Women's Crisis Team. The team serves women who are both drug abusers and domestic violence victims.

Approximately one-half of the States (49%) and the communities (55%) coordinate with other programs in behalf of battered women. Approximately 25 percent of the States participate in an agency or program task force, committee or council (e.g., Governors' Advisory Councils, Commissions on Women) which focuses some or all its efforts on the problem of domestic violence. Coordination activities at the local level appear to be somewhat more common than at the State level. Informal meetings and service agreements with other providers are more typical (35% and 28%, respectively) than the sharing of staff (21%) or participation in a task force or committee. A number of community drug

programs have developed referral procedures and service agreements with regional addiction centers, halfway houses, hospitals, mental health centers, and social service agencies which provide counseling and shelter to battered women.

Some drug programs work closely with law enforcement agencies and crime prevention programs to develop police training, workshops, court-witness programs, and volunteer services. One local drug treatment program surveyed is part of a consortium organized on the local level to coordinate the State's service delivery and treatment system and to develop shelter programs, an advocacy network, and training for police and program staff. Another program is part of a special task force, consisting of the State Commission on Drugs, the Status of Women and Crime, CETA, the Department of Public Welfare, and the State's Domestic Abuse Program. This task force is studying the extent to which drug abuse and domestic violence are interrelated. In another community, drug treatment personnel help to staff both the crisis hotlines for an active Women's Aid organization and a group counseling service for abusing spouses.

In 55 percent of the States and 45 percent of the communities, drug program staff were identified as advocates for battered women. Several State program administrators reported success in obtaining funds from various sources for model projects and demonstration programs, which include such components as shelter care, crisis care, counseling, and staff training. Other State-level staff work to forge linkages among drug programs and other service providers who benefit victims of spousal abuse. In addition, technical assistance to local programs, staff training, and community education are provided by both State and community staff.

In one community, the administrator of the drug treatment program has established and maintained active involvement in the national movement toward family counseling. He and some of his staff have attended the White House Conferences on Families and on Domestic Violence and are knowledgeable about special counseling techniques with violent families. Reportedly, this staff interest and expertise greatly enhance the program's service delivery to battered women, within the context of drug addiction and violent family behaviors. In another community's non-residential drug treatment program, professionals from other agencies and organizations serve as "contract staff"; they are paid (by the session) to provide counseling to clients of the drug program. In this way, a range of expertise and skills are obtained, when needed, by the program. The director of this program also spoke on the issue of domestic violence at a substance abuse seminar.

Barriers to Service Delivery

In 61 percent of the States and 55 percent of the communities, respondents identified barriers which restrict the drug programs' capacity to address the needs of battered women. The major barrier, perceived by virtually all respondents, is that reimbursement can be made only for services provided to those persons whose primary problem is drug abuse. Services to collaterals (non-drug abusers in a family or living unit) are not reimbursable. Therefore, programs are not likely to serve a battered woman who is not a drug abuser.

Another barrier relates to the availability and nature of services. Some drug treatment facilities are available to men only. Thus, even when a battered woman is a substance abuser, her treatment options may be severely limited because the local facility cannot accommodate females. In addition, when a battered woman with addiction problems is admitted, entry may be to a medically oriented, drug treatment or hospital detoxification program where the issue of spousal abuse is secondary.

Other barriers influenced by Federal or State regulations, appropriations or practices include: the confidentiality of records which limits opportunities for referrals; the absence of clear policies or guidelines regarding provision of services to spousal abuse victims; the lack of funds; the high cost of providing services in rural areas; the lack of trained staff, especially with regard to those skilled in treating women, battered or not; and the fact that when spouses of drug abusers do receive services from the program, it is available only as long as the drug abuser is currently receiving treatment. In addition to these influences, respondents also noted that the lack of child care services within drug treatment programs may preclude women with children from utilizing treatment resources.

Program staff also cited attitudinal barriers which impede service provision to battered women The point was made that, historically, drug programs always have had trouble attracting women. This problem is due, in part, to the embarrassment women feel about revealing drug abuse as a problem; the strong values of family privacy and pressures to solve problems of violence or addiction within the family unit; the desires of women to remain at home rather than enter residential treatment; and the emphasis on confrontation within many drug treatment programs. Intensifying these difficulties is the reluctance of drug abusers and their families to seek aid because of the illegal nature of most drug use.

In three-quarters of the communities, respondents feel that community resources are inadequate to meet the needs of battered women. Services are either limited or non-existent. While crisis intervention services may be available, there frequently is no follow-through, and intermediate programs for "out-clients" are seldom available.

Program Recommendations to Enhance Services Delivery

Program respondents offered several recommendations to enhance service delivery to battered women within drug treatment programs. Among those programs which are involved in some type of coordination activity in behalf of battered women, respondents identified steps needed to improve coordination efforts. At both the State and community levels, recurrent themes emerge: 1) designation of an agency, board or committee to take the lead in coordination and 2) development and dissemination of information on the problem of spousal abuse and the resources available for victims and their families.

Several program changes also were suggested. Primary among them is that both NIDA and NIAAA need to look at substance abuse as a family issue. Federal regulations should be changed to permit service delivery to family members,

who more often are the victims of the substance abuser rather than being substance abusers themselves. Second, it was suggested that an orientation toward providing services to women, in general, is needed. Some respondents felt that available treatment strategies are inadequate to meet the needs of the female drug abuser whose problems are compounded if she is also battered.

At the community level, respondents identified several activities which have enhanced or will enhance their own efforts to serve battered women. In several instances, the establishment of a shelter or the availability of a broader spectrum of services to victims provides improved resources for referral and consultation. In two different communities, grant applications to NIDA are pending. One is for provision of direct services to victims of spousal abuse, and the other is to support a study of battered women. In one State, a newly passed law gives battered women greater legal protection, and, at the local level, the CAP agency has hired a staff person to cooordinate local services and provide information for women in crisis. These initiatives are viewed as strengthening the local drug programs' capacity to assist the battered women they encounter in their clientele. Finally, several respondents spoke of an increased sensitivity to the needs of battered women on the part of their staff, arising largely from concerted community education and emphasis on programs for spouse abuse victims.

Recommendations for staff training and technical assistance (T&TA) were elicited from all respondents. Among the types of T&TA considered helpful in increasing program staff's ability to meet the needs of battered women and their families are the following:

- Dynamics of spousal abuse--a general orientation for State office staff and a detailed review for local clinical staff;
- Relationship between spousal abuse and substance abuse;
- Legal perspectives on the problem and permissible intervention procedures; for example, how to protect the children;
- Interviewing techniques, assessment of service needs, and treatment approaches;
- Resource development and establishment of a coordinated service provider and referral network; and
- Information on the availability of literature, training and technical assistance, program models, services, etc., at the national level.

SUMMARY

Drug treatment programs appear to have the potential to serve abused spouses and their families. Some State and local drug treatment programs already are providing direct services to victims as a focal group within the program's broader service population. Many more programs coordinate their spouse abuse intervention efforts with other agencies. The major barrier to increasing this level of involvement, according to respondents, is the lack of Federal reimbursement for services delivered by drug treatment programs to family members of substance abusers.

STATE FUNDED DOMESTIC VIOLENCE PROGRAMS

PROGRAM OVERVIEW

In recent years, several States have begun to address the problem of spousal abuse through State legislation which authorizes and allocates funds for domestic violence programs. As a result, States have established pilot projects and/or expanded existing programs in selected communities to meet the needs of abused spouses and their families. At the time the State Survey was conducted, 16 States had such State authorized and funded programs.

The population eligible to receive services from State funded domestic violence programs varies from program to program and from State to State. Many programs serve anyone who is a victim of domestic violence while others have more stringent eligibility criteria.

In practice, State funded programs are providing services primarily to battered women. Services most frequently provided to these victims are emergency shelter care, crisis intervention, transportation, counseling and referral through hotlines. Many programs also have services for the children of battered women, such as shelter care, day care, and recreational activities. Although several programs include services for battered men, reportedly, few men request these services. Some programs provide counseling services for abusing spouses.

ABSTRACT OF MAJOR PROGRAM FINDINGS

The findings presented in this report are based on information obtained from interviews with State level domestic violence program administrators and with staff from community programs receiving State funding. Interviews were conducted with State level administrators of 17 State funded programs located in 15 of the 16 States having such programs. At the community level, interviews were conducted with staff from eight State funded domestic violence programs located in eight communities across three States. The following is an account of the major findings resulting from these interviews.

- In 77 percent of the States and 75 percent of the communities, program staff have established definitions of domestic violence.

- Along with a focus on battered women, at the State level, 88 percent of the programs focus on the children of battered women, 59 percent on abusing spouses, and 35 percent on battered men. In comparison, at the community level, 88 percent of the programs focus on the children of battered women, 25 percent on abusing spouses, and 38 percent on battered men.

- In 77 percent of the States and in all of the communities, program staff are involved in coordination activities on behalf of battered women.

- Respondents in 77 percent of the States and 63 percent of the communities reported that Federal or State legislation, regulations or policies restrict the program staff's ability to meet the needs of battered women.

- In 77 percent of the States and in all the communities, program staff have received some training to understand better the needs of battered women.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

The following discussion examines State funded programs goals, services, and coordination linkages with other programs. Barriers to service delivery and recommendations for change, as identified by respondents, also are discussed.

Specific Program Efforts

Across the State funded programs surveyed, program goals range from meeting the woman's immediate need for emergency shelter care to long-term objectives of preventing domestic violence. Grassroots efforts, increased public awareness, local needs assessments, and enabling State legislation have provided much of the impetus for these goals.

Respondents were asked about the problems most frequently presented by the battered women seeking assistance from their programs. They identified other forms of marital conflict, housing (both emergency and permanent), social isolation, child care, and unemployment.

Although the types of services offered by all of the programs surveyed are quite similar, there is variation in strategies used by staff to deal with the problem of domestic violence. Specifically, in sixty-three percent (63%) of the programs surveyed, staff reported a greater focus on crisis intervention than on ongoing services. In 75 percent of the programs surveyed, staff view their first priority as assuring the physical safety of the victim through provision of emergency shelter. Twenty-five percent (25%) of the program staff surveyed favor court intervention with abusers, while 63 percent find that therapeutic intervention is more consistent with their program's approach.

Staffing patterns within the different programs also vary. Seventy-five percent (75%) of the community programs primarily employ professional staff while the remaining 25 percent rely primarily on lay staff. The type of staff often reflects the service philosophy of the program. For example, one program employs only professional staff who operate within a mental health treatment model and use confrontive counseling approaches. Staff of this program aim to help battered women achieve independence without any reliance on social service/public assistance programs. In contrast, several of the programs which employ lay staff tend to view one of their functions as assisting battered women in gaining access to social service/public assistance programs.

A self-help/peer support intervention model is used by 75 percent of the programs surveyed; 25 percent function within a more traditional social services model. Generally, program approaches are similar with respect to the length of time battered women are served; the average time is from two weeks to one month. However, some programs provide follow-up counseling for up to one year.

Several State programs have features which the respondents consider to be unique and innovative. These unique features include: 1) peer counseling provided by former battered women, 2) the transfer of victims to other localities as necessary for their safety, and 3) the use of the confrontive counseling approach.

Along with providing direct services to abused spouses and their families, in many State funded domestic violence programs, staff have engaged in coordination efforts, data collection, needs assessments, program monitoring and evaluation, consultation and community education.

At the State administrative level, 77 percent of the program staff are involved in coordination activities on behalf of battered women. Participation in committees and/or task forces was reported by several respondents. The efforts of these groups have focused on the coordination of services, lobbying, fund raising, the development of standards and regulations, and general problem solving. State level respondents also reported on coordination efforts occurring at the local level. They cited linkages among shelter programs and other service providers, including mental health services, child protective services, social services, drug abuse and alcoholism treatment programs, and law enforcement agencies. Through these linkages, service agreements have been established, referral mechanisms have been developed, and some training for law enforcement officers has been provided.

In addition to coordination activities, data collection efforts by State funded programs also were described by respondents. For example, in one State, State funds have been used to establish a Domestic Abuse Registry. The Registry contains data collected on incidence, type of abuse, and whether legal action is taken against the abusing spouse. Reporting of incidents of domestic violence to the Registry is required of law enforcement officers.

In addition to the services already being provided by program staff, several respondents thought it feasible for their programs to increase community education and direct service activities. Other potential areas for expansion include legislative advocacy and "re-entry education."

Barriers to Service Delivery

Federal and State barriers impeding delivery of services to abused spouses through State authorized and funded programs were identified by respondents in 77 percent of the States and 63 percent of the communities. The barriers fall into two major categories: those inherent in the domestic violence programs' operations, funding sources, eligibility requirements; and, those deriving from other programs' eligibility criteria.

Eligibility requirements in several domestic violence programs result in denial of services to some battered women. Among the types of requirements imposed to qualify for services are the following: the victim and abuser must have engaged in a sexual relationship; the victim must have residency in the State, and, in some instances, in the county; if the victim and the abuser are not legally married, the victim must have a child who is in jeopardy of abuse; and/or the victim cannot be a substance abuser, a mentally retarded person, or

a person with severe medical or physical problems. In addition, some shelters, because of space limitations, cannot accept victims with more than three children. Others exclude victims who have not conformed to program requirements in the past and/or victims experiencing psychological/emotional abuse but no physical abuse.

Financial problems constitute another barrier for a number of State domestic violence programs. Insufficient funding and anticipated budget cuts, which would reduce the programs' current level of services, were cited by many respondents. In some States, more specific funding restrictions were noted: 1) funds are provided for only six months at a time, making long-range planning difficult; 2) funds are legislated for shelter care only, excluding services for women who choose not to go to shelters; 3) funds are allocated for services only, placing the burden of the purchase and upkeep of shelters on local resources; 4) funds from the State require a 60 percent match in local funds; and/or 5) funds budgeted, but not authorized by statute, are subject to cuts at any time.

There were other State specific financial constraints identified as well. For example, in one State, the mental health board has advocated for the licensing of shelters as mental health facilities; yet, the costs of bringing shelters up to the required standards are beyond shelter program resources. Burdens on shelter program budgets also are exacerbated by some programs' lack of eligibility for surplus properties and sales tax exemptions. Respondents from one State also reported that State funds cannot be used to reimburse domestic violence programs for group counseling services.

On the local program level, additional types of barriers to meeting the needs of battered women were identified by respondents. Some communities have zoning ordinances which, in effect, restrict the locations of shelters. Another barrier, cited by one respondent, is the community attitude that shelter locations remain secret. As a result, the shelter must close when its location becomes known, creating a gap in service delivery until another facility is established. In many areas, permanent housing is not available for battered women with low incomes, or the women are unsuccessful in gaining priority for low cost housing. Program service related barriers also identified include the lack of day care services for children and the lack of funds to hire staff.

The second major category of barriers relates to Federal and other program regulations. According to many respondents, eligibility criteria for Aid to Families With Dependent Children (AFDC), Title XX, Medicaid, and Food Stamp programs frequently restrict the battered woman's access to needed services. Inclusion of the husband's assets and income to determine eligibility for assistance, despite the fact that the battered woman may not have access to the husband's resources, is considered a primary factor in finding the woman ineligible.

Other program practices also restrict provision of services to battered women. With regard to AFDC, the following examples were cited by respondents: some AFDC programs refuse to grant assistance to women in shelters; many AFDC programs take several weeks to determine eligibility; and, at least one State's

AFDC program has a one-year residency requirement. With regard to Title XX, some States require that clients be identified by name on vouchers submitted for reimbursement. This is viewed as a barrier because it violates shelter confidentiality agreements with victims. Another limitation of Title XX, cited by respondents, is that the funds cannot be used for the purchase or repair of shelter facilities. Further, in some States, adult protective services, which are partially funded by Title XX, are available only for elderly or mentally retarded persons, thus excluding many battered women.

Anticipated budget cuts in CETA and LEAA funds also pose a threat to many shelter programs currently relying on these funds to supplement State monies. A further problem reported with regard to receipt of LEAA funding is that extensive paperwork and recordkeeping are required.

Legal problems also were noted in providing protection and services to victims; these relate primarily to respondents' beliefs that most States' laws do not provide adequate relief for the victim from the abusive situation. In addition, the legal aid offices in some States require physical separation of the wife from the husband for a specified time period before staff will consider only the woman's income in the determination of eligibility for assistance.

As evident, many of the barriers noted by domestic violence program respondents are specific to other programs. Respondents emphasized that since staff rely heavily on other programs to help meet the multiple needs of victims and their families, restrictions in these programs have a direct impact on their referral and service options.

Program Recommendations to Enhance Service Delivery

Respondents suggested resolutions to some of the barriers mentioned above and offered recommendations to enhance service delivery. Coordination efforts with other agencies should be improved, according to many program respondents. Specific suggestions include developing a directory of State and community resources, establishing a service provider network which includes law enforcement agencies, and working with DHHS funded programs to resolve existing barriers, especially those related to eligibility. For example, in some locations, coordination efforts have resulted in the "liberalization" of AFDC guidelines regarding eligibility; however, these changes have not become uniform across the State. Thus, respondents stressed the importance of coordination with DHHS funded programs on an on-going basis to enable battered women to receive services.

Respondents expressed an interest in further training and technical assistance in the following areas: working with abusing spouses, the dynamics of domestic violence, general counseling skills, crisis intervention skills, grant writing, and information on how to gain access to NIMH, HUD, and other funding sources.

Program respondents were asked to report on suggestions which have been offered by battered women to improve services. The needs and suggestions expressed to program staff by battered women are similar to the needs identified by staff: more responsive police intervention, emergency financial assistance, permanent housing, and child care.

Legislative efforts in several States are having positive effects on domestic violence programs and may increase their capacity to assist victims. In one State, a recently passed bill provides continued funding for a domestic violence program which began as a pilot project. Another State amended its domestic violence legislation to include persons who are separated, divorced, have a child in common, or are related "through household affiliation." Other States' legislative efforts which may affect service provision to battered women include legislation to impose a tax on marriage licenses, with the supplemental funds to be used for support of domestic violence programs, and a bill that would allow injunctions to be served against the abuser even when not married to the victim.

SUMMARY

State authorized and funded domestic violence programs are emerging as one avenue through which the needs of battered women and their families are being addressed. This is occurring through a variety of shelter arrangements, service coordination strategies, and service delivery models. However, because of the multiple service needs of many victims and the barriers to service delivery, problems have arisen in effecting an integrated network of service providers. While there is much more to be accomplished, promising steps have been initiated by staff of State funded programs as well as by the individuals and agencies assisting them with their efforts.

OTHER DOMESTIC VIOLENCE PROGRAMS/ SHELTERS FOR BATTERED WOMEN

PROGRAM OVERVIEW

This category includes programs established primarily through local grassroots organizations to meet the needs of abused spouses and their families. The majority of these programs focus on the provision of emergency shelter care. However, there are other types of programs included such as victim witness programs, a women's resource center, a center against sexual assault, a family guidance center, and a travelers' aid program.

Funding for these grassroots programs varies; some receive Federal monies, for example, from Title XX, LEAA, CETA, and/or VISTA. Others receive partial funding from the State or county and/or from foundations, private contributors, the United Way, the YWCA, religious groups, and income earned from speaking engagements and other fund raising activities.

Although all of these programs provide services to abused spouses, some have established specific target populations. For example, some programs limit their services to the physically abused, whereas others also serve the emotionally abused. Others exclude victims who are considered substance abusers, mentally ill, or developmentally disabled. One program has a broad target population that includes any individual who is abused by any family member (e.g., a spouse, a sibling, or a parent abused by a child) and homosexual couples.

In addition to shelter care, crisis intervention, counseling, transportation, and advocacy services are provided by these programs. Several programs also operate hotlines, usually staffed by paraprofessionals and volunteers.

ABSTRACT OF MAJOR PROGRAM FINDINGS

The study findings presented in this discussion are based on data obtained through personal interviews with respondents from 59 programs in 48 communities, located in 14 of the 15 States selected for the Community Survey.

The 59 programs in this sample were identified in one of three ways. Some were identified by State Survey program respondents, others were identified through written materials, and approximately 25 percent were identified by CSR's Community Survey field staff because they have "close and substantive working relationships" with other programs surveyed in the community.

The following points summarize the major findings related to these grassroots programs.

- In 68 percent of the programs, staff have established definitions of domestic violence.

- Ninety-three percent of the programs focus on battered women; 71 percent on the children of battered women; 42 percent on abusing spouses; and 41 percent on battered men.
- In 90 percent of the programs, staff are involved in coordination activities on behalf of battered women.
- In 90 percent of the programs, staff have received training to better understand the needs of battered women and their families.
- Sixty-one percent of the respondents identified other programs in their communities that also assist victims.
- Legislation, regulations or policies creating barriers to service provision to battered women were identified by 59 percent of the respondents.

ANALYSIS OF PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

This section presents a descriptive analysis of the activities engaged in by the 59 grassroots domestic violence programs selected for the Community Survey.

Specific Program Efforts

General program goals and objectives are similar for most of the programs surveyed; these pertain to the provision of shelter care for women and children coupled with support services. Many programs also have goals related to prevention and community education.

The types of facilities used for shelters vary. Some programs have separate facilities and some are located in existing facilities such as YWCAs. One program provides shelter through the use of extra beds at a mental health transitional living program. Others have networks of "safe homes," often the homes of formerly battered women. In one community, the Salvation Army provides shelter and food on a short-term basis. In this situation, the women and their children are not allowed to remain in the facility during the day; the expectation is that they need to be out solving their problems.

A few of the programs surveyed provide transitional or second-stage housing as well as emergency shelter. Many of the programs include a 24-hour hotline. Hotline staff usually provide crisis counseling as well as information and referral. Respondents for one hotline reported that the service began as a rape crisis line, but that staff found the majority of their calls were about spouse abuse. Other support services provided by shelters may include individual, group and family counseling; transportation; vocational services; legal services; and advocacy. In addition to the provision of direct services, approximately 75 percent of the respondents reported staff involvement in collecting incidence statistics, program planning, needs assessment, and community education.

Twenty-five of the programs surveyed provide some services/assistance for abusing spouses. One program that targets on abusing spouses provides crisis and ongoing counseling, family or couples counseling, and community education. This program serves battered women and their children only as secondary clients and has determined that abusing spouses do not usually seek help until their wives leave them. Another program's hotline is available to provide crisis counseling for abusing spouses.

Although all of the shelters include accommodations for children, only a few respondents cited program components for children such as day care or special recreational activities. One program does operate an unlicensed school, staffed by a State-certified teacher, and another program provides a "RAP" group for children of battered women. A few programs also offer "parenting skills" which could benefit children indirectly.

The length of stay permitted in shelters varies from three days to up to six weeks. Service provision for nonshelter services ranges in time from the length of a phone call to up to a year for follow-up service. The budgets for the grassroots programs also vary considerably. Some programs operate on a "shoe-string" budget while others have annual budgets of between $80,000 and $260,000. One program with an annual budget of $80,000 served 439 battered women last year. Another program with an annual budget of $250,000 provided shelter care and other services for 781 women and children last year.

The primary problems presented by battered women seeking help, as reported by the program respondents, include other forms of marital conflict, a need for emergency and/or permanent housing, and a need for legal protection from their spouses.

Not all of the programs surveyed provide shelter care. Four programs are involved primarily with the court system. Two of these programs are victim-witness programs. In one of these, staff work with victims of non-drug-related felonies, assisting battered women, but not as a special target population. The other victim-witness program does target on battered women; staff provide direct intervention and mediation with the battered women and their spouses.

In the third court-connected program, staff provide counseling, help clients "walk through the system," and advocate for treating rather than punishment of abusing spouses. The staff also have received special training on mediation techniques. The fourth program involves the placement of student interns (criminal justice majors) in its District Attorney's office. The interns act as court advocates for assault on female cases in those instances when defendants plead "not guilty." One of the objectives of this program is to get a higher number of women to follow through on court action after initial warrants are served on their abusing spouses.

Among the respondents interviewed from grassroots programs, there is a fairly equal distribution between those reporting that their programs use primarily professional staff and those reporting a reliance on lay staff. A majority of respondents reported that their programs are crisis oriented and focus first on providing the victim with safe shelter. Fifty-three percent of the respondents indicated that their program's philosophy leans toward favoring court intervention with abusing spouses over therapeutic intervention.

Approximately two-thirds of the respondents described their programs as using self-help models of service intervention.

Respondents also provided information on several other activities undertaken by program staff. Many of the programs surveyed have active community education components. For example, staff utilize public media, engage in public speaking, and provide educational services to local police departments. In one community, program staff have worked very actively with the police department. As a result, officers from this department routinely carry cards identifying available women's services which they, in turn, give to women when responding to domestic violence calls. Another program assigns staff to provide crisis intervention at the local police station and at local hospital emergency rooms.

In another community, program staff go to schools to educate children on how to deal constructively with anger. Staff from two other programs reported active involvement with the legal profession. In one of these programs, a lawyer advises women free of charge for the first session. In the other, a lawyer conducts a two-hour seminar on women's legal rights on a monthly basis.

As mentioned previously, 90 percent of the respondents also indicated that program staff coordinate with other community agencies to help battered women. Usually these agencies include social services, substance abuse, and mental health centers. Staff efforts focus on facilitating referrals and on avoiding duplication of services. Finally, some respondents believe it is feasible for their programs to take on additional activities, especially in the areas of coordination, community education, and services for abusing spouses.

Barriers to Service Delivery

This section contains a discussion of the various difficulties encountered by program staff in their attempts to meet the needs of abused spouses and their families.

The lack of adequate Federal and/or State funds for domestic violence programs is a frequent complaint voiced by respondents from grassroots programs. Even when funds are available, through CETA or Title XX, restrictions reportedly are imposed by having to comply with the Federal or State regulations for these programs. For example, shelter staff have concern about revealing the identities of women served by their programs to obtain reimbursement through the Title XX program.

Many of the barriers identified by respondents relate to other Federal programs with which the grassroots programs must interact in providing comprehensive support services for battered women. Eligibility criteria for Aid to Families with Dependent Children and Emergency Assistance programs often are cited by respondents as being too stringent. Further, the determination process for these programs can be so lengthy that often the women leave the shelter prior to the time that eligibility is established. As a result, the shelter cannot be reimbursed for the services provided.

Problems reported at the local level include restrictions on shelter facilities imposed by zoning laws, fire codes, and health department regulations. In addition, respondents from one grassroots program reported that they have experienced difficulty with the local Child Welfare Services program which claims the shelter is not complying with the State's child abuse and neglect reporting laws. This is an issue because the shelter has a policy of not making referrals or sharing information without the client's permission.

In some instances, program policy limits the availability of services to battered women. For example, one program requires that the woman be living with the abuser at the time of referral, and another program is only open to county residents. One respondent believes that the use of the YWCA is inadequate and inappropriate because battered women are mixed with other residents, and staff have too many other tasks to be totally responsive to the needs of battered women. Finally, one program reported a unique eligibility criterion which may impede the staff's ability to meet the needs of battered women. All women, without high school diplomas, who want to receive program services must work towards a graduate equivalency degree (GED).

The groups most frequently identified as not seeking help from shelter programs were upper-class women, Hispanics, Native Americans, and Blacks. Respondents believe that upper-class women do not seek help from grassroots programs because they have other resources, are too embarrassed to reach out for help, fear exposure, and/or do not want to enter unsafe urban neighborhoods where programs may be located. On the other hand, respondents believe that minority group women do not seek assistance because cultural acceptance of violence is more common among them and because program outreach efforts are in need of further development.

Limited funds and lack of staff were noted as the primary reasons why these programs are not able to do more outreach or assume any other activities to help victims. Further, 80 percent of the respondents indicated that the resources in their communities are not adequate to meet the multiple needs of victims and their families. The services seen as lacking or insufficient include shelters, low cost permanent housing, day care and other services for children, job training, financial assistance, legal assistance, and long-term counseling. Judging by how frequently respondents made reference to them, budget and staff cuts are a constant threat to domestic violence programs.

Program Recommendations to Enhance Service Delivery

Many of the respondents' recommendations addressed the need for better service coordination among agencies. Respondents would like to have a more formalized service network, a clearinghouse of resources, clarity on referral procedures, newsletters, and interagency meetings to discuss problems, goals, and specific cases. Others expressed the need for more emphasis on prevention, community education, and staff training. A few respondents mentioned a desire for more active involvement with their State coalitions against domestic violence, and at least one respondent believes it would be helpful if the State established a priority on domestic violence intervention.

Efforts to better serve battered women are already underway in some communities. For example, in one area, the police department has become more responsive to the needs of battered women, resulting in an increased number of referrals from the police to shelter programs. In another community, where there is a new State law allowing warrantless arrests and other civil remedies, the shelter staff plan to provide training for members of the criminal justice system.

Respondents also reported suggestions received from battered women for improving services. In terms of initial program contact, battered women have suggested walk-in services rather than telephone contacts, and direct telephone contacts rather than answering services. Battered women also have requested more input into domestic violence programs and the day-to-day operation of shelters. In reference to other community resources, battered women have expressed a need for permanent housing, police support, adequate financial aid, and legal aid. Battered women have also suggested that eligibility for legal aid not include consideration of the spouse's income.

SUMMARY

The grassroots domestic violence programs are beginning to meet the needs of battered women in several communities. These programs are experiencing some success in helping battered women improve their situations and are active in raising community awareness of the problem of domestic violence. However, the need for more funding and more staff is a recurring theme with respondents.

Further, the results of the survey suggest there are still many unmet service needs among battered women, and that many battered women are not seeking services. There appears to be a concensus among clients and staff in terms of barriers to service delivery and unmet service needs. The existing grassroots programs are starting to fill some of these gaps.

CONCLUDING REMARKS

The previous series of program reports has provided many examples of staff activities occurring across States and communities to help victims of domestic violence and their families. Although these activities are not widespread, there are staff in each program surveyed who are taking steps to respond to the problem of domestic violence.

Table 2-1 summarizes the various activities occurring on State and local program levels across 11 of the DHHS funded programs selected for study. These activities are taking place within the parameters of the various Federal program mandates; they demonstrate the flexibility States and communities have in applying DHHS program resources to the problem.

In the next Chapter, an overview of Study findings and additional tables are presented to facilitate further comparison between and among the various programs studied.

TABLE 2-1

Percent of State and Community Programs Reporting Activities Directed on Battered Women

DHHS Programs	TYPE OF ACTIVITY											
	Program Funding		Collection of Statistics		Needs Assessment		Program Planning		Program Monitoring		Program Evaluation/ Research	
	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %
Aid to Families With Dependent Children	4	3	2	8	2	3	2	3	0	0	0	0
Emergency Assistance	5	7	0	7	0	10	9	0	0	0	5	0
Child Welfare Services	17	3	14	3	20	3	14	0	6	0	6	0
Child Protective Services	17	3	15	10	15	6	11	7	11	0	7	0
Medicaid	2	0	0	0	0	0	0	0	0	0	0	0
Social Services	32	7	20	18	18	9	26	7	28	11	18	11
Community Health	N/A	4	N/A	4	N/A	16	N/A	4	N/A	4	N/A	4
Community Mental Health	17	14	12	25	10	25	7	43	10	21	5	18
Work Incentive Program	0	0	2	0	4	0	0	0	0	0	0	0
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	20	3	20	14	24	17	22	10	10	3	8	3
Drug Abuse Demonstration and Community Service Programs	25	10	18		22	17	22	14	14	3	8	7

*The base numbers for all percentages are presented in Exhibit 1.

TABLE 2-1 (continued)

Percent of State and Community Programs
Reporting Activities Directed on Battered Women

DHHS Programs	TYPE OF ACTIVITY: Technical Assistance/ Consultation		Staff Conduct/ Provide Training		Community Education		Clearinghouse/ Information on Domestic Violence		Direct Services		Coordination Activities		Other*	
	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %
Aid to Families With Dependent Children	2	3	10		0	3	0	0	2	10	24	35	2	0
Emergency Assistance	5	3	0	7	0	0	0	0	18	17	36	33	0	0
Child Welfare Services	26	6	20	9	20	3	11	6	17	0	49	39	20	3
Child Protective Services	15	7	13	13	11	3	4	3	20	10	39	52	11	0
Medicaid	0	0	0	0	2	0	0	0	2	3	8	17	0	0
Social Services	24	16	20	24	16	13	14	11	38	25	56	29	22	7
Community Health	N/A	16	N/A	20	N/A	8	N/A	8	N/A	16	N/A	40	N/A	8
Community Mental Health	12	29	20	29	24	39	17	21	27	43	32	71	0	21
Work Incentive Program	2	0	4	0	4	0	2	3	10	7	16	38	4	0
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	28	10	30	7	22	7	14	3	20	10	56	38	14	10
Drug Abuse Demonstration and Community Service Programs	22	14	27	24	20	10	18	7	22	24	49	55	14	10

*Examples of "Other Activities" include lobbying, advocacy, and legal services.

*The base numbers for all percentages are presented in Exhibit 1.

CHAPTER 3: STUDY FINDINGS FROM A NATIONAL PERSPECTIVE

This Chapter provides an overview of the major study findings across all the programs surveyed at the State and local program levels. These findings are organized into three major sections:

- Scope of Current DHHS Program Efforts.
- Analysis of DHHS Program Potential to Serve Battered Women and Their Families.
- State and Local Domestic Violence Program Initiatives.

Study findings on the DHHS funded programs surveyed do not include any data on the number of domestic violence victims identified by staff, the number receiving program services, or the costs of program activities related to the problem. Except for isolated exceptions, respondents from DHHS funded programs responded that staff are not collecting these types of data. Therefore, the reader should not look to this discussion for that type of information. Rather, this discussion presents study findings which may be used to support decisions in the future concerning: 1) the expansion of DHHS funded program activities directed on victims and their families, 2) resolutions to both actual and perceived barriers to service delivery, and 3) better use and coordination of existing State and local program resources.

Before presenting various findings relevant to the above points, the next section reviews the study sample.

STUDY SAMPLE

Exhibit 1 on the page following provides a breakdown of the study sample. The percentages presented in the text and tables of the report (unless otherwise noted) are based on the number (N) of programs surveyed at the State level and at the community level. These numbers vary by program. For example, the State Survey findings for the Aid to Families with Dependent Children (AFDC) program are based on an N of 51. This N of 51 is the total possible sample--State level AFDC administrators in all 50 States and the District of Columbia participated in the State Survey. At the community level, survey findings for the AFDC program are based on an N of 40. Findings from these 40 local AFDC programs are considered representative of all local AFDC programs throughout the country, since both the communities and programs within communities were selected randomly. This sampling approach holds for all the DHHS funded programs surveyed at the local level.

SCOPE OF CURRENT DHHS PROGRAM EFFORTS

This section examines the extent to which DHHS funded programs, at State and local levels, are directing attention to the needs of abused spouses and their families. Survey findings on four areas of possible staff involvement are presented:

EXHIBIT 1

DISTRIBUTION OF STUDY SAMPLE

Program Area	Number of States Surveyed	Number of Communities Surveyed
Aid to Families With Dependent Children	51	40
Emergency Assistance	22	30
Child Welfare Services	35	33
Medicaid	48	36
Social Services (excluding Protective Services)	50	45
Child Protective Services*	46	31
Adult Protective Services*	5	2
Child Abuse and Neglect Prevention and Treatment	N/A	6
Community Health	N/A	25
Community Mental Health	41	28
Indian Health Services**	11	4
Work Incentive	50	29
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	50	29
Drug Abuse Demonstration and Community Service Programs	49	29
State Funded Domestic Violence Programs	17	8
Other Domestic Violence Programs	N/A	59
Other Programs	9	10
TOTAL	484	444

*As noted, in addition to interviews with representatives of the Social Services program, interviews were conducted with staff providing specialized child protective and adult protective services. These latter services are funded primarily through the Social Services program.

**The Indian Health Services program is administered through 11 Area Offices which serve Native Americans in 29 States. Staff from all the Area Offices provided data on the activities occurring within their respective geographic regions.

- The decision to focus on victims within the program's broader eligible service population.
- The establishment of a program definition of domestic violence.
- The development of program goals pertaining to the needs of victims.
- The implementation of program activities (e.g., direct services, coordination of resources, staff training) to benefit victims and their families.

Despite the fact that none of the DHHS programs under review have a Federal mandate to target on victims of spouse abuse, study findings do show that some State and local staff are involved in each of these four areas of study.

Domestic Violence Victims as a Focus of Program Efforts

Each DHHS funded program surveyed is authorized to provide financial assistance/services to individuals or families who meet the program's eligibility criteria. The eligibility criteria vary from program to program but, in general, the selected programs concentrate on helping persons who have incomes under specified levels and/or who have specified service needs.

Although the legislative mandates for the DHHS programs surveyed do not reference victims of spouse abuse as a target population, some victims are eligible to receive program services. These victims possess other characteristics which concur with the program's mandate and eligibility criteria. Of special interest to this study is the extent to which State and local staff, on their own initiative or in response to State or community concern, have singled out victims as a focus of program efforts. Table 2 presents survey data on this area of inquiry.*

At the State level as shown on Table 3-1, an emphasis on battered women varies considerably across the DHHS funded programs surveyed. None of the Work Incentive Program (WIN) respondents reported a focus on battered women, while respondents from 34 percent of the Social Services program reported this focus. This varied emphasis on battered women is found at the community level as well. None of the WIN or Medicaid programs surveyed at the local level have a focus on battered women, while 29 percent of the Community Mental Health Centers do. With the exception of several respondents from the Child Welfare Services program reporting a focus on the children of battered women, the other victim groups are less likely than battered women to be a focus of any DHHS funded program efforts.

*Statistical findings for the Indian Health Services (IHS) and the Child Abuse Prevention and Treatment (NCCAN) programs are omitted from Table 3-1 and some of the subsequent tables because the administrative structure of IHS and the size of the NCCAN sample do not permit meaningful comparison with the other DHHS funded programs studied.

TABLE 3-1

Percent of State and Community Programs Reporting a Focus on Specific Groups of Domestic Violence Victims

DHHS Programs	GROUPS							
	Battered Women		Battered Men		Children of Battered Women		Abusing Spouses	
	State %	Community %	State %	Community %	State %	Community %	State %	Community %
Aid to Families With Dependent Children	6	5	4	0	4	0	2	0
Emergency Assistance	14	17	5	3	9	10	0	0
Child Welfare Services	17	0	6	3	51	33	9	6
Child Protective Services	13	3	4	0	28	23	4	7
Medicaid	2	0	0	0	0	0	0	0
Social Services	34	27	24	11	26	33	16	13
Community Health	N/A	4	N/A	0	N/A	0	N/A	0
Community Mental Health	27	29	12	14	22	21	12	18
Work Incentive Program	0	0	0	0	0	0	0	0
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	24	10	4	3	10	10	8	10
Drug Abuse Demonstration and Community Service Programs	22	10	6	3	6	3	4	3

*The base numbers for all percentages are presented in Exhibit 1.

The Table 3-1 data also show that where DHHS funded programs have a focus on battered women, a larger proportion of State level respondents than community respondents report this focus. (The two exceptions to this trend are Emergency Assistance and Community Mental Health Center programs.) Divergence between State and local program respondents' reports is particularly evident in five of the DHHS funded programs surveyed: the Child Welfare Services, Child Protective Services, Social Services, Alcoholism Treatment and Rehabilitation/Alcohol Formula Grants, and Drug Abuse Demonstration/Community Service programs. It may be that while activities to help battered women are planned or discussed by staff of these programs at the State level, the realities of funding and staff limitations lead staff at the community level to report only on activities which are implemented.

In brief, these findings show that few staff of DHHS funded programs are focusing on battered women as a special subpopulation, particularly staff involved in direct intervention at the local level. The children of battered women, battered men, and abusing spouses are the focus of program efforts even less often. However, the few State and local DHHS funded programs with a focus on victims and their families demonstrate that States and communities have flexibility in determining program emphases within the broad legislative mandates of these DHHS programs.

Defining the Problem of Domestic Violence

This study also investigated the extent to which staff of DHHS funded programs, at State and local levels, have established/adopted a definition of domestic violence. The existence of a definition indicates formal recognition of the problem. The results of this inquiry are presented in column 2 of Table 3-2.

Very few DHHS funded programs have established or adopted definitions of domestic violence. At the State level, Social Services (22%) and Alcoholism Treatment programs (18%) are more likely than other DHHS funded programs to have such definitions. At the community level, the Emergency Assistance (23%), Child Protective Services (16%), and Social Services (16%) programs are more likely to have established a definition.

Most frequently, respondents from the programs with a definition of domestic violence indicated that the definition originated in State domestic violence legislation. Examples of definitions range from the very broad (e.g., "any individual in need of services due to abuse, neglect, or exploitation") to very specific definitions delineating the types of physical and/or emotional abuse, conditions of residence under which the abuse must occur, and the relationship or former relationships of the persons involved. A powerful use of a definition is illustrated by some Emergency Assistance programs, which use the definition of domestic violence to establish service eligibility; that is, "battering" constitutes an "emergency."

In brief, these findings show that most DHHS funded program staff are operating without a program definition of domestic violence. This factor may be curtailing staff recognition of domestic violence as a problem experienced by their service population. On the other hand, the establishment of a very specific program definition of domestic violence was cited by some respondents as restricting staff from responding to the needs of victims seeking services.

TABLE 3-2

Percent of State and Community Programs Reporting Efforts on Behalf of Battered Women

DHHS Programs	EFFORTS									
	Program Focuses on Battered Women		Program Has Definition of Domestic Violence		Program Has Goals to Assist Battered Women		Program Provides Services Specifically for Battered Women		Program Works With Other Agencies to Coordinate Services for Battered Women	
	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %
Aid to Families With Dependent Children	6	5	4	8	4	8	2	10	24	35
Emergency Assistance	14	17	9	23	14	17	18	17	36	33
Child Welfare Services	17	0	9	12	11	3	17	0	49	39
Child Protective Services	13	3	9	16	17	3	20	10	39	52
Medicaid	2	0	0	3	0	6	2	3	8	17
Social Services	34	27	22	16	20	16	38	25	56	29
Community Health	N/A	4	N/A	12	N/A	8	N/A	16	N/A	40
Community Mental Health	27	29	5	4	15	32	27	43	32	71
Work Incentive Program	0	0	2	0	0	3	10	7	16	38
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	24	10	18	7	26	10	20	10	56	38
Drug Abuse Demonstration and Community Service Programs	22	10	12	10	20	14	22	24	49	55

*The base numbers for all percentages are presented in Exhibit 1.

Establishing Program Goals

Across the programs surveyed, there is considerable flexibility granted by DHHS to States and communities in the determination of program goals, as long as the goals have relevance to the broader legislated mandate. Thus, one purpose of this study was to assess the extent to which DHHS funded programs, at State and local levels, have goals pertaining to the needs of abused spouses and their families. Table 3-2, third column, summarizes study findings on this area.

Again, the findings show that some State and local staff are taking advantage of the flexibility provided within their respective program mandates. At the State level, this is especially true of staff from the Social Services (20%), Alcoholism Treatment (26%) and Drug Abuse programs. At the local level, Community Mental Health Center staff (32%) have exercised this option most often.

Of note are the differences across DHHS funded programs in the extent to which State and community programs have developed goals to assist battered women. In some programs (e.g., Child Protective Services and Alcoholism Treatment) a larger percentage of State than community respondents identified such goals. Perhaps, some State plans include those goals, but the goals are not adopted consistently by all community service providers. In contrast, in other programs surveyed (e.g., Medicaid and Community Mental Health Centers), a larger percentage of local than State level respondents identified goals for battered women. Some local staff apparently are establishing these goals in response to the problem of spouse abuse evidenced in their community.

Examples of goals addressing the needs of battered women, reported by DHHS funded program respondents, include:

- To give service priority to the children of battered women.
- To coordinate program services with the Adult Protective Services program.
- To establish domestic violence identification, screening, and referral mechanisms.
- To serve as advocates for battered women.
- To extend assistance to battered women residing in shelters.
- To protect the health and safety of battered women.
- To simplify the application process for battered women.

Although a minority of DHHS funded programs surveyed have goals such as those listed above, there appears to be the potential for further development in this area.

Providing Services and Coordinating Resources

All DHHS funded programs offer services which battered women and their families may receive on the basis of their broader eligibility for program assistance. There were no data available from respondents which would show the number of these victims currently receiving various program services. However, Exhibit 2 on the page following shows the primary services which could potentially be offered to eligible victims through DHHS program resources. Although not all States and communities offer all of the services listed on the Exhibit, the services shown are especially pertinent to the needs of abused spouses.

Beyond the assessment of services generally available, this study also was interested in documenting: 1) DHHS funded programs providing some services especially for abused spouses and their families, and 2) DHHS funded programs working with other agencies to coordinate services on behalf of abused spouses. Findings on these two areas are presented in the fourth and fifth columns of Table 3-2.

Across all DHHS funded programs surveyed, a minority of States and/or communities have elected to provide some special services for battered women. At the State level, those programs most frequently reporting special services include Social Services (38%), Community Mental Health Centers (27%), Drug Abuse (22%), Alcoholism Treatment (20%), and Child Protective Services (20%). At the community level, it is the Community Mental Health Center (43%), Social Services (25%), and Drug Abuse Treatment (24%) programs which are more inclined to have special services.

A broad range of activities was reported by respondents from the DHHS funded programs offering special services to victims and their families. Examples include:

- Providing food, clothing, and temporary shelter.
- Offering various supportive services such as counseling and client advocacy.
- Assigning specialized staff to work with battered women identified by other program staff.
- Training staff to serve as paralegals for battered women involved in court processes.
- Operating crisis 24 hour hotlines.
- Establishing special family counseling and peer group counseling services for victims.

Although the above points suggest that some DHHS program resources can be directed especially on victims of spouse abuse, the vast majority of respondents indicated that their programs have few, if any, resources which could be used especially for victims and their families. However, many respondents

EXHIBIT 2

DHHS Services Potentially Available to Battered Women Who Meet Eligibility Requirements

	SERVICES*									
DHHS PROGRAMS	Temporary Shelter/ Residential Care	Crisis Intervention	Medical	Counseling	Legal	Employment/ Vocational	Child Care	Financial Assistance	Transportation	Advocacy
Aid to Families with Dependent Children						X (expenses may be considered)	X (expenses may be considered)	X	X (expenses may be considered)	X
Emergency Assistance	X	X						X		X
Child Welfare Services	X (for children)	X		X	X (court related)		X			X
Child Abuse and Neglect Prevention Treatment	X	X	X	X	X (court related)	X	X	X	X	X
Indian Health Services		X	X	X						X
Medicaid			X	X			X		X (for medical care)	X
Social Services	X	X	X (related to employment)	X	X	X	X		X	X
Community Health		X	X	X						X
Community Mental Health	X	X	X	X	X (court related)					X
Work Incentive Program			X (related to employment)	X		X	X			X
Alcoholism Treatment and Rehabitation and Alcohol Grants	X	X	X	X						X
Drug Abuse Demonstration and Community Service Programs	X	X	X	X						X

*Services listed are those considered most relevant to the needs of battered women and their families; some services are not available to some States/communities.

reported that program staff are attempting to assist victims through coordination efforts with other agencies. Thus, it is not surprising that many respondents also believe that State and local coordination of services is the most feasible future program activity.

To reinforce the coordination potential, the study findings show that, at the State level approximately 50 percent or more of the following DHHS funded programs are already coordinating activities with other agencies to benefit battered women: Child Welfare Services (49%), Social Services (56%), Alcoholism Treatment and Rehabilitation/Alcohol Formula Grants (56%), Drug Abuse Demonstration and Community Service Programs (49%). At the community level, Child Protective Services (52%), Community Mental Health Centers (71%), and Drug Treatment (55%) programs are frequently involved in coordination activities for battered women.

Coordination Strategies

DHHS funded program staff have used several mechanisms to coordinate activities with other agencies, for example, participation on State/local domestic violence task forces, Governor's Advisory Councils, and Commissions on Women; service agreements with other programs/agencies; informal meetings with other program staff to discuss service provision to victims and their families; and the sharing of staff on jointly-sponsored activities related to the problem of domestic violence. Table 3-3 presents the percentages of DHHS funded progams involved in these various activities. These data suggest the following:

- About one-fourth of the States and communities surveyed have established some kind of interagency mechanism, like a task force or committee to consider the needs of battered women.
- Service agreements and the sharing of staff are less common mechanisms used to achieve coordination to benefit battered women. At the same time, the Community Mental Health, Alcoholism Treatment and Drug Abuse programs do report some notable level of involvement in these coordination activities, primarily at the community level.
- The informal meeting is the mechanism most frequently used by program staff to coordinate activities on behalf of battered women.
- Within the Child Welfare Services and Social Services programs, coordination activities intended to benefit battered women are more likely to occur at the State than the community level. Within other DHHS program settings (with the exception of Community Health which does not have an administrative structure at the State level), coordination is more likely to occur at the community than the State level.

Respondents identified some specific accomplishments resulting from these coordination activities: 1) clarification of DHHS financial reimbursement policies for services provided by shelters to battered women; 2) establishment of formalized referral procedures between and among programs; 3) increases in the numbers of battered women referred by programs to various needed services; 4) the development of DHHS and shelter record keeping procedures to ensure client confidentiality; 5) joint staff training on domestic violence issues;

TABLE 3-3

Percent of State and Community Programs Reporting Coordination Activities on Behalf of Battered Women*

DHHS Programs	TYPE OF COORDINATION ACTIVITY									
	Program Task Force or Committee		Service Agreement		Informal Meetings		Sharing of Staff		Other	
	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %
Aid to Families With Dependent Children	8	10	4	10	8	20	4	13	8	5
Emergency Assistance	14	7	5	13	14	23	0	7	18	0
Child Welfare Services	23	15	17	9	29	21	14	12	14	9
Child Protective Services	15	26	7	13	17	29	7	13	15	13
Medicaid	2	6	2	3	2	6	4	0	2	3
Social Services	22	11	16	9	32	18	14	7	20	2
Community Health	N/A	12	N/A	16	N/A	12	N/A	8	N/A	12
Community Mental Health	12	32	2	21	12	46	5	39	17	25
Work Incentive Program	2	7	0	17	10	10	2	14	6	17
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	30	10	12	24	28	24	18	21	18	7
Drug Abuse Demonstration and Community Service Programs	25	14	14	28	22	35	14	21	14	17

*The base numbers for all percentages are presented in Exhibit 1.

6) publication of a resource handbook for victims of domestic violence; 7) collection of needs assessment and incidence data; and 8) community education campaigns.

The coordination activities assumed by program staff in some States and communities include a wide spectrum of human service programs (e.g., the Departments of Social Services, Education, Criminal Justice, Transportation, Public Health, and Coalitions Against Domestic Violence). On the community level, however, coordination is more likely to involve a small number of program staff who operate on a case-by-case basis.

Advocacy and Staff Training

This study also examined the extent to which DHHS funded programs are involved in advocacy and staff training related to the problem of domestic violence. Respondents were asked to report any advocacy activities on behalf of victims occurring within and/or outside their program and any staff training related to the problem (see Table 3-4).

Across all DHHS funded programs surveyed, some program staff identified themselves or co-workers as advocates for domestic violence victims. These advocates are more likely to work within the Alcoholism Treatment, Drug Abuse, Social Services, Child Protective Services, and Child Welfare Services programs. DHHS program staff are engaged in several kinds of advocacy activities: 1) flexibility in interpreting program regulations to facilitate services to battered women; 2) involvement in community education campaigns; support of the establishment of shelter programs; 3) inclusion of services for battered women in program plans and budgets; 4) lobbying for State domestic violence legislation; and 5) sharing knowledge with battered women about services available in the community. The staff interviewed for the Indian Health Services program also see themselves as advocates for battered women. Their efforts focus on encouraging Native American battered women to advocate more for themselves and on encouraging tribal governments to recognize domestic violence as a serious problem on the reservation.

In addition to their own efforts to advocate for battered women, program staff are very aware of other advocacy efforts for battered women taking place in their States and communities (see column 2, Table 3-4). The vast majority of respondents commented that the advocacy activities assumed by various groups have resulted in positive contributions. They most often noted increased public awareness of the problem, passage of State domestic violence legislation, and the development of shelters and other services in the community for battered women and their families.

Respondents from DHHS funded programs also were asked to report on any training they or their co-workers had received to better understand the problem of domestic violence (see column 3, Table 3-4). Across all DHHS funded programs surveyed, some staff have received this training. With the exception of the Child Welfare Services and Child Protective Services programs, this is a more common occurrence for program staff at the community level than at the State level. On the local level, a large percentage of the Community Mental Health Center (71%), Drug Abuse (48%), Alcoholism Treatment (45%), Social Services (44%), and Child Protective Services (42%) programs have staff who received some specalized training.

TABLE 3-4

Percent of State and Community Program Staff Involved in and/or Aware of Advocacy Efforts and Percent of Staff Who Have Received Specialized Training

DHHS Programs	ADVOCACY AND TRAINING ACTIVITIES					
	Program Staff Identified as Advocates for Domestic Violence Victims		Program Staff Aware of Advocacy Activities Outside the Program for Domestic Violence Victims		Program Staff Received Training in Area of Domestic Violence	
	State %	Community %	State %	Community %	State %	Community %
Aid to Families With Dependent Children	14	25	80	68	8	10
Emergency Assistance	23	27	77	83	23	23
Child Welfare Services	40	30	91	70	40	30
Child Protective Services	30	26	80	74	41	42
Medicaid	4	22	56	61	6	19
Social Services	46	36	80	67	34	44
Community Health	N/A	32	N/A	76	N/A	32
Community Mental Health	37	75	73	93	22	71
Work Incentive Program	18	38	76	66	28	24
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	60	55	82	86	38	45
Drug Abuse Demonstration and Community Service Programs	55	45	80	79	43	48

*The base numbers for all percentages are presented in Exhibit 1.

Summary

This section of the report has reviewed the extent to which, and the manner in which, various DHHS funded programs are involved with the problem of spouse abuse. A significant number of the programs are engaged in coordination, advocacy, and staff training activities pertaining to the problem of spouse abuse. To a much lesser degree, DHHS funded programs have goals and services especially for victims. There is considerable variation in the extent to which different DHHS funded program staff become involved with victims and their families. This is to be expected, given the differences in eligibility requirements, program focus, and latitude in planning mechanisms characterized by the DHHS funded programs surveyed.

Both the State and Community Surveys provided an opportunity to gather program respondents' comments. Many of these are not easily quantified; however, an analysis of respondent comments suggests that those programs most actively involved with the issue of spouse abuse possess particular characteristics:

- Staff of the program are identified as advocates for battered women and their families.
- Program staff interpret general program policies, goals, and eligibility guidelines broadly.
- Program staff coordinate activities with other agencies equipped to assist victims.
- The program has a State mandate to serve victims of domestic violence.

Many DHHS funded programs surveyed at both the State and community level are not characterized by these descriptions. However, there is nothing in DHHS program mandates which would prohibit these programs from becoming more involved with victims and their families. At the same time, other factors tend to limit DHHS program assistance for this population. These barriers are examined in the following section.

ANALYSIS OF DHHS PROGRAM POTENTIAL TO SERVE BATTERED WOMEN AND THEIR FAMILIES

One of the purposes of this study is to assess the potential for further DHHS program involvement with the problem of spouse abuse. This potential is assessed in this section by reviewing respondents' perceptions of the problem, respondents' identification of barriers to service delivery, and respondents' suggestions for improving services to victims and their families.

Perceptions of the Problem

Respondents were asked to comment on the severity of the problem of domestic violence, to identify factors which may contribute to the problem, and to identify other problem areas frequently experienced by battered women.

As Table 3-5 shows, the vast majority of respondents, at the State and community level, across all DHHS funded programs believe that domestic violence is a severe problem. Most respondents also believe that economic factors such as financial stress and unemployment are an underlying cause (see Table 3-6). State and community respondents tend to agree less often with regard to other underlying factors. State level respondents identified societal factors (such as sex role stereotypes and the changing role of the family) second only to economic factors, whereas local respondents more frequently commented on the presence of substance abuse, particularly alcoholism, as a factor related to spousal abuse. Familial factors such as learning abusive behavior within the family, personal factors such as emotional difficulties and stress, and interpersonal factors such as communication problems were generally identified with the same frequency by State and local respondents.

Table 3-7 shows the variety and range of problems presented by battered women, as identified by respondents of the DHHS funded programs surveyed. Respondents across all programs stated that more than 60 percent of the battered women in their service populations experience other forms of marital conflict, including emotional abuse. Between 40 and 50 percent of the respondents also identified social isolation, housing, legal protection, unemployment, and alcohol abuse by the spouse as frequent problem areas.

Program staff perceive housing as one of the major unmet needs of battered women (see Table 3-8). Except for temporary shelter, this need probably cannot be met directly through DHHS program resources. However, many of the needs identified by program respondents potentially could be met, at least partially, through DHHS program resources. As shown previously in Exhibit 2, the DHHS funded programs surveyed offer a range of services relevant to the needs of victims and their families. For example, the AFDC and Emergency Assistance programs offer families financial assistance; Child Welfare Services, Child Protective Services, Social Services, and Community Mental Health Centers offer counseling and crisis intervention services; the Work Incentive Program offers employment-related services, and the Alcoholism Treatment and Drug Abuse programs offer counseling and rehabilitation services.

The many problems experienced by battered women, coupled with unmet service needs, make it clear that no one program has sufficient resources to become totally responsible for this population. Therefore, the potential of program involvement with victims is seemingly related to the use of internal program resources and the pooling of resources across programs. Identification and referral of victims and their families also is critical if service needs of victims are to be met.

The majority of local respondents surveyed, across all DHHS funded programs, believe that it is the community's responsibility to meet the needs of victims and their families. At the same time, the majority of local respondents believe that existing resources in their communities are inadequate for meeting the needs of this population (see Table 3-9). This latter point is emphasized by noting that respondents in nearly one-half of the communities surveyed commented that special resources, such as advocacy programs, hotlines, or shelters for battered women, do not exist in their community.

TABLE 3-5

Perceptions of State and Community Program Staff on the Problem of Domestic Violence

DHHS PROGRAMS	PERCEPTIONS OF DOMESTIC VIOLENCE*					
	Agree That It Is a Severe Problem		Disagree That It Is a Severe Problem		No Opinion %	
	State %	Community %	State %	Community %	State %	Community %
Aid to Families With Dependent Children	84	85	2	13	14	3
Emergency Assistance	78	83	0	13	23	3
Child Welfare Services	94	97	0	0	6	3
Child Protective Services	87	100	0	0	11	0
Medicaid	61	81	6	19	31	0
Social Services	92	93	0	4	8	2
Community Health	N/A	96	N/A	0	N/A	4
Community Mental Health	91	96	2	4	7	0
Work Incentive Program	68	93	6	0	26	7
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	98	93	0	3	2	3
Drug Abuse Demonstration and Community Service Programs	96	97	0	0	4	3

*Percentages may not equal 100 due to rounding.

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*The base numbers for all percentages are presented in Exhibit 1.

TABLE 3-6

Percent of State and Community Program Staff Identifying Factors That Contribute to Domestic Violence

DHHS PROGRAMS	CONTRIBUTING FACTORS															
	Familial		Societal		Economic		Personal		Substance Abuse		Interpersonal		Other		Don't Know	
	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %
Aid to Families with Dependent Children	22	20	35	25	86	80	47	25	31	75	14	15	6	10	4	0
Emergency Assistance	18	17	36	23	91	90	46	33	23	50	27	30	0	13	0	0
Child Welfare Services	29	27	60	55	80	64	26	46	20	64	11	15	0	3	0	0
Child Protective Services	17	32	52	42	78	71	37	39	37	58	24	19	7	13	4	0
Medicaid	6	17	29	33	55	78	33	39	29	69	17	19	4	17	21	0
Social Services	30	24	58	40	81	80	36	36	32	53	20	20	0	16	2	0
Community Health	N/A	28	N/A	44	N/A	80	N/A	40	N/A	32	N/A	20	N/A	12	N/A	4
Community Mental Health	32	14	68	64	63	61	37	36	46	39	12	25	5	4	2	0
Work Incentive Program	16	21	40	48	80	97	46	38	24	66	24	17	2	0	0	0
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	18	10	60	41	52	55	32	38	70	79	18	14	8	3	2	3
Drug Abuse Demonstration and Community Service Programs	22	14	55	59	57	45	37	45	51	45	25	31	8	7	0	0

*The base numbers for all percentages are presented in Exhibit 1.

TABLE 3-7

Perceptions of Community Program Staff on Frequency of Problems Experienced by Battered Women*

PROBLEM AREA	FREQUENCY OF OCCURRENCE (%)**			
	Less Than 30%	30-60%	More Than 60%	Don't Know
Other Marital Conflicts	2	13	78	8
Unemployment	17	29	43	12
Alcohol Abuse by Spouse	8	39	43	10
Drug Abuse by Spouse	49	30	6	15
Physical Health Problems	51	22	12	16
Mental Health Problems	25	33	32	11
Developmental Disability	78	4	0	17
Pregnancy	62	15	5	18
New Baby in Home	53	22	4	21
Emotional Abuse by Spouse	7	15	66	12
Child Care Problems	30	28	28	15
Child Behavior Problems	22	38	23	18
Child Abuse by Spouse	35	32	16	17
Social Isolation	13	22	49	15
Housing (emergency or permanent)	22	22	48	9
Transportation	27	25	34	15
Legal Protection from Spouse	16	23	47	15

*The total N for this question is 250 (55.5%).
**Percentages may not equal 100 due to rounding.

*The base numbers for all percentages are presented in Exhibit 1.

TABLE 3-8

Percent of State and Community Program Staff Identifying Unmet Service Needs of Domestic Violence Victims

DHHS PROGRAMS	UNMET SERVICE NEEDS											
	Housing		Medical		Crisis Intervention		Mental Health		Legal Services		Vocational Services	
	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %
Aid to Families with Dependent Children	29	55	4	10	0	0	21	28	0	21	13	17
Emergency Assistance	18	55	0	0	0	0	9	27	0	0	0	14
Child Welfare Services	61	80	7	0	7	7	21	60	11	17	4	7
Child Protective Services	62	72	5	0	10	10	21	48	13	14	10	14
Medicaid	50	52	17	19	0	0	6	38	6	19	0	10
Social Services	61	76	0	0	3	3	31	57	6	16	17	5
Community Health	N/A	65	N/A	0	N/A	6	N/A	35	N/A	0	N/A	12
Community Mental Health	62	48	0	0	9	0	21	26	18	9	9	13
Work Incentive Program	52	63	0	0	10	0	24	42	5	11	0	21
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	51	46	5	14	8	0	15	46	3	5	10	23
Drug Abuse Demonstration and Community Service Programs	56	60	10	5	7	0	7	20	5	10	7	0

*Percentages are based only on those program respondents who identified unmet service needs.

*The base numbers for all percentages are presented in Exhibit 1.

TABLE 3-8 (continued)

Percent of State and Community Program Staff Identifying Unmet Service Needs of Domestic Violence Victims

DHHS PROGRAMS	UNMET SERVICE NEEDS											
	Child Care		Transportation		Financial Assistance		Advocacy		Services for Abusing Spouses		Needs Related to Staffing and Service Delivery	
	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %	State %	Community %
Aid to Families with Dependent Children	0	10	0	7	21	14	0	7	4	3	21	3
Emergency Assistance	0	0	0	5	27	9	0	0	27	14	0	9
Child Welfare Services	0	7	0	0	11	17	0	3	4	27	43	10
Child Protective Services	0	7	0	7	10	31	5	3	13	17	33	10
Medicaid	0	5	0	10	6	19	0	5	0	24	11	5
Social Services	3	3	3	5	0	14	0	0	17	16	17	5
Community Health	N/A	12	N/A	0	N/A	6	N/A	0	N/A	12	N/A	24
Community Mental Health	18	17	3	4	3	30	0	4	3	26	32	0
Work Incentive Program	0	16	0	16	0	21	0	5	0	21	43	32
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	13	14	0	5	10	9	0	0	0	9	36	0
Drug Abuse Demonstration and Community Service Programs	17	15	0	0	10	10	0	5	5	30	44	5

*The base numbers for all percentages are presented in Exhibit 1.

TABLE 3-9

Perceptions of Local Program Staff on Community Responsibility for Meeting Needs of Battered Women and the Adequacy of Community Resources

DHHS PROGRAMS	Agree That It Is the Community's Responsibility %	Agree That Community Resources Are Inadequate %
Aid to Families With Dependent Children	78	68
Emergency Assistance	97	63
Child Welfare Services	82	91
Child Protective Services	90	87
Medicaid	72	70
Social Services	82	87
Community Health	84	76
Community Mental Health	93	79
Work Incentive Program	97	62
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants	93	79
Drug Abuse Demonstration and Community Service Programs	90	76

*The base numbers for all percentages are presented in Exhibit 1.

Data show that most staff of DHHS funded programs recognize spouse abuse as a severe and complex problem requiring the local provision of many different services. Respondents also perceive their communities as having insufficient resources to meet the service needs. The following section discusses additional barriers identified by respondents as restricting their programs from filling the gaps in the service delivery system.

Barriers to Service Delivery

Program respondents identified multiple barriers which they believe restrict their programs from responding to the needs of battered women and their families. Some of these barriers are viewed as resulting from Federal and State legislation and regulations. Other barriers are seen as resulting from limited program resources available to deal with the problem. Finally, there are barriers perceived as a result of community attitudes and of the victims' characteristics.

Before discussing the specific barriers identified by respondents, it is important to review a major concern expressed by respondents. Respondents repeatedly noted that it is not within the purview of their programs to provide any special assistance to victims and their families. While it is true that some of the DHHS funded programs surveyed cannot target services on any special population not eligible by legislative mandate (e.g., income eligible, or eligible because of substance abuse), the mandates do not preclude staff from initiating special activities to help victims who are eligible for basic program services.

Some of the perceived barriers reported here might be eliminated with a modest investment in staff training to increase awareness of exemplary efforts assumed by programs in other communities and States. For example, respondents made numerous references to the surveyed program's authorizing Federal legislation. On the one hand, many respondents believe that their programs are restricted because of legislative mandates to focus on populations other than abused spouses and their families; for example, "children," the "medically underserved," the "mentally ill," or "substance abusers." On the other, respondents also believe that the lack of a legislative mandate to target battered women and their families deters staff from becoming engaged in domestic violence intervention activities.

Many respondents noted that the absence of State legislation on domestic violence or on the protection of "vulnerable" adults also restricts staff authority to intervene in situations of domestic violence. In States where there is adult protective legislation, many respondents indicated that the legislative intent does not necessarily include victims of spouse abuse. Rather, the legislation focuses on helping adults who are unable to manage their own affairs because of age, mental, or physical disabilities.

Respondents from several programs, particularly the WIN, Community Mental Health Center, Alcoholism Treatment and Drug Abuse programs, noted that Federal and State regulations on financial reimbursement restrict them from helping battered women and their families. Some WIN respondents, for example, reported that there are no reimbursable service categories related to the problem of domestic violence. Drug Abuse program respondents reported that services

extended to family members of substance abusers often are not reimbursable. Thus, respondents from these programs commented that battered women whose husbands are the substance abusers usually are not provided with any direct program services.

Respondents also noted that several DHHS funded programs have established separate processes for determining an applicant's financial eligibility and service eligibility. Many respondents perceive that strict interpretation of this policy deters the identification and referral of battered women by income maintenance staff. Many respondents also believe that they are deterred from referring victims to other programs because of issues related to client confidentiality.

The limited availability of program resources is viewed as another major barrier to serving battered women. Funding and staffing shortages already curtail activities in ongoing mandated program areas; most program respondents consider the commitment of additional funding and staff as necessary prerequisites to expanding services to battered women and their families.

Community attitudes apparently further restrict DHHS funded programs' capacity to assist battered women. Repeatedly, community resistance to intervening into "private" family life was noted by respondents. Such community attitudes apparently extend into the service provider network as well. Several respondents, for example, indicated that they, themselves, lack knowledge about the problem of domestic violence and about the availability of community resources to deal with the problem. Others reported that it is difficult to coordinate services for battered women because agencies have different priorities, eligibility guidelines, and policies.

Many respondents noted barriers to service delivery created by the battered woman's personal situation. For example, battered women with no children are not eligible for AFDC, Emergency Assistance, Child Welfare Services, Child Protective Services, or WIN program services. In addition, battered women must meet the income, residency, and/or other types of eligibility criteria specified by the DHHS funded programs. This means that while similar basic services are needed by most battered women, eligibility for those services has to be determined on a case-by-case basis. This is a time consuming task which most agency staff are not mandated to assume.

Further, many respondents believe that battered women are generally reluctant to seek program services, because they are afraid of their spouses' reaction, are too embarrassed to admit to being battered, feel there is a stigma attached with receipt of "welfare" or "psychiatric" services, or are afraid that their children will be placed in foster family homes. Other respondents believe that battered women often are unaware of services available, or have no means of transportation to programs offering the services they need.

Finally, one significant barrier, reported by more than one-half (51%) of the DHHS funded program respondents at the community level, is that their programs have no intake procedures for identifying battered women. Thus, battered women and their families are not routinely identified or referred to other service providers.

In brief, a variety of barriers are perceived by respondents as interfering with the development of program strategies to assist victims of domestic violence and their families. Some of these barriers result from actual constraints on program resources, lack of community support, or lack of staff knowledge on how to identify and intervene with victims and abusers. Other barriers, however, stem from staff misinterpretation of program mandates, policies, and regulations. Clarification of these latter areas by Federal and State administrators appears to be a significant prerequisite to further use of DHHS program resources for victims.

Some DHHS funded programs surveyed are able to address the needs of battered women in spite of the barriers noted above. Special staff activities, described in the previous Chapter and in the first section of this Chapter, serve as examples of what can be done to assist battered women who meet the program's eligibility criteria. In addition, program respondents offered other suggestions for resolving barriers to service delivery. These recommendations are discussed in the next section.

Respondent Recommendations to Enhance Service Delivery

Program respondents were asked to suggest ways for improving the delivery of services to victims and their families. These recommendations were offered as ways to overcome some of the barriers. Suggestions offered relate to changes in: 1) program mandates, regulations, and resources; 2) internal program policies and procedures; 3) interagency linkages; and 4) training and technical assistance activities.

Many respondents expressed the need for changes in current program mandates, regulations, and resource allocations to enable direct service provision and other activities on behalf of battered women and their families. They suggested: 1) revision of program mandates to permit and/or encourage the targeting of DHHS activities on victims of domestic violence, 2) revision of program regulations to allow Federal reimbursement for services to all members of a client's family, and 3) clarification of issues of client confidentiality with respect to reporting cases of spouse abuse and sharing information with other service providers. In addition, nearly all respondents emphasized that their programs need additional resources (funding and staff) to focus specifically on the service needs of battered women and men, abusing spouses, and their children.

Recommendations regarding internal program policies and procedures primarily pertain to changes at the local program level. Respondents recommended the establishment of agency intake policies, which require probes for the identification of spouse abuse as well as procedures to follow once the problem is identified. When spouse abuse is the reason why a woman is in need of service, they suggest speeding up the application process or waiving some of the eligibility requirements which may place her in further danger (e.g., pursuit of child support, returning home to obtain documents necessary for verification of assets, birth records, etc.).

Appointing staff as domestic violence intervention and referral specialists is another suggestion made to facilitate the program's responsiveness to

victims and their families. Several respondents believe that the development/expansion of crisis intervention, family treatment, and group counseling approaches within their agencies would further facilitate the delivery of services to battered women.

Respondents also have suggestions for improving interagency linkages and the coordination of services provided by various agencies. Although they recognize battered women have a range of service needs, many respondents suggest that one agency be designated as the focal point of domestic violence intervention. This State/local agency would assume primary responsibility for community and professional education, service coordination, and direct intervention. In addition, this agency would help staff from other programs to clarify their roles and options in domestic violence cases. Staffing and funding from various programs could be combined to provide this agency with resources needed to carry out its activities. Further, respondents suggest that formal referral and follow-up procedures on behalf of victims and their families be developed among agencies.

Finally, respondents suggest that program staff receive training/technical assistance to improve their capacity to intervene with families experiencing domestic violence, including training on:

- Topics to increase staff awareness of and sensitivity to the problem of spouse abuse and to the families experiencing the problem.
- The underlying psychological dynamics of spouse abuse and accompanying family dynamics.
- Physical as well as other indicators of spousa abuse.
- Specialized interviewing, crisis intervention, and counseling techniques.
- Service needs of battered women and their families and resources available in the community (and neighboring communities) to meet those needs.
- The legal rights of abused spouses.
- The effects of spouse abuse on children.
- Ways to identify, understand, and help abusing spouses.

Respondents also recommend that current information on the extent of the problem and how other programs are responding be shared with them.

Summary

Study findings presented in this section indicate that most staff of DHHS funded programs are aware of the problem of spouse abuse, its complexity, and the special service needs of victims. They also recognize that many service needs of victims are not being met through existing community resources.

Program staff in a few States and communities have directed their concern about the problem on the development of special intervention strategies to benefit victims. Some staff are taking steps to develop service delivery networks; others are requesting guidance in this area. Actions such as these illustrate the potential use of DHHS program resources to help those battered women and their families who meet the program's eligibility criteria.

Several recommendations made by respondents for improving the delivery of services to victims can be implemented easily--staff training, procedures to identify victims and hasten application processes, and coordination among service providers. At the same time, in assessing the potential for applying DHHS program resources to the delivery of services for victims, one cannot overlook the fact that many barriers, both actual and perceived, need to be clarified so that resolutions also can be developed. One barrier which exceeds the potential of current DHHS program resources is that some victims are not eligible for any DHHS funded program services. The current and potential role of State funded and grassroots domestic violence programs to fill this service gap, as well as others, is examined in the next section.

STATE AND LOCAL DOMESTIC VIOLENCE PROGRAM INITIATIVES

During the State and Community Surveys of DHHS funded programs, CSR staff identified two types of special programs which are evolving to meet the needs of abused spouses and their families: 1) State funded and authorized domestic violence programs and 2) local grassroots programs. The emergence of these programs suggests that victims have some needs which require specialized intervention. Thus, this section summarizes study findings on the current and potential service delivery role of those programs.

Extent of Current Services

The number of States and communities with specialized programs for abused spouses and their families was documented through this study effort. At the time of the State Survey, 16 States, or 31 percent of all States, had a State funded domestic violence program. Of the 88 communities selected for the Community Survey, 48 communities, or 54 percent, had one or more grassroots programs. This percentage reflects the growing number of local grassroots efforts throughout the country.

To date, staff of these State and local programs are focusing their efforts on battered women and their children. Services most frequently provided include emergency housing, hotline counseling and referral, crisis intervention, and transportation. Some of these programs also provide services to the battered woman's family, such as housing accommodations for children, family and group counseling, and, in a few instances, counseling for the abusing spouse.

Since data on victims were not available from the DHHS funded programs surveyed, a review of data collected from these special programs provides the only opportunity to report on some characteristics of victims seeking services. These findings, however, should be interpreted broadly, because the numbers reported by most programs are estimates rather than actual counts.

Data from a random sample of 31 of the grassroots programs were aggregated for this review. Data also were aggregated for six of the State funded programs sampled. A total of 27,374 battered women received services during the past year from the grassroots programs sampled. Individual program counts ranged from 19 to 10,904 with the higher numbers including calls received by program staff through hotlines as well as women reached through community education activities. Low numbers, on the other hand, reflect programs which were just starting up at the time of the Community Survey or programs in rural settings.

A total of 1,321 battered women received services from the six State funded programs sampled. The number of victims served by individual programs ranged from 12 to 670. Again, this wide range is explained by the type of services provided (e.g., hotline, shelter, counseling), the date of implementation, and the location.

Additional information analyzed the subsamples of these special programs provides some insight to when battered women seek help and their living conditions before and after they seek this help:

- Only three percent of the battered women served had contacted the program after their first incident of abuse, while more than 90 percent made their first request for assistance after repeated incidents of abuse.

- Over 90 percent of the battered women were living with their spouse at the time they sought help. After contact with the program, an estimated 45 percent of the women returned to their spouse, while 30 percent established separate households. Living arrangements of the remaining 25 percent were unknown.

- Over 59 percent of the women reported violent episodes between their own parents, and 31 percent reported abuse as children.

Further, many of the staff from these special programs reported that they are providing their services to a primarily white, lower economic class of women. The staff expressed concern about minority group and upper class battered women who apparently are not yet turning to them for help.

Service Potential

The staff of the State funded and grassroots programs surveyed identified several barriers which currently limit their potential to help victims and their families. Most of these barriers are similar to those identified by respondents from the DHHS funded programs. For example, they repeatedly identified lack of program funds and staff, restrictions imposed by DHHS program eligibility criteria, and inadequate community resources. Shelter program staff also emphasized the difficulties they encounter when trying to meet local zoning ordinances and residency requirements.

The special program staff surveyed believe that their future potential to help victims of domestic violence depends, to a considerable degree, on the resolution of these barriers. Some of these staff already have diminished the

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negative impact of the barriers by working closely with the staff of DHHS funded and other programs. Further, many staff believe that further collaborative efforts will result eventually in a comprehensive service delivery system for victims and their families. The establishment of more interagency service agreements and formalized referral mechanisms are viewed as the next steps toward this goal.

At this time, however, there is serious question as to whether the goal of a comprehensive service network for victims will be realized. Most of the State funded and grassroots programs surveyed are in financial jeopardy. Many of these programs operate on a pilot or demonstration basis without any promise of long-term funding. In addition, States and communities are experiencing budget cuts across all social programs which most likely will deter the development of new programs. If the goal is to be realized, the pooling of State and community resources is a necessary prerequisite. There also must be service strategies developed which prevent the duplication of services at the local level.

Summary

State funded and grassroots programs are making important contributions to the delivery of services for victims and their families. Often, these programs are providing services, such as emergency housing and specialized crisis intervention, which are not available elsewhere in the community. Staff also are providing services to abused spouses who are not eligible for DHHS program services. Program staff are increasing community and government awareness of the special service needs of victims.

Victims of domestic violence, in turn, are increasingly turning to both the special programs and DHHS funded programs for help. Staff of the DHHS programs surveyed view the specialized programs as critical referral resources for their clients. It appears that the resources of both are necessary if victims' needs are to be met, even partially.

One must remember that these special programs do not exist everywhere. Nearly one-half of the communities across the country have no special programs, not even hotlines or crisis intervention programs, for battered spouses. Further, many of the special programs which do exist are experiencing severe financial difficulties. Services for children and abusing spouses are virtually undeveloped everywhere.

These study findings, coupled with the data presented on the DHHS programs surveyed, reinforce the fact that there is no one program which can meet all the service needs of victims and their families. Rather, the challenge ahead is learning how to make better use of existing program resources available through Federal, State, and local auspices.

The next Chapter explores the relationship between various types of programs and variables which potentially could influence service delivery to victims and their families. This discussion may assist in making policy decisions affecting future efforts to help victims.

CHAPTER 4: SPECIAL ANALYSES OF STATE AND COMMUNITY SURVEY FINDINGS

This Chapter presents additional statistical analyses on three issues related to this study effort:

- The relationship between State and community level program activities to help victims.
- The differences, if any, between DHHS funded activities in States with and without a State funded domestic violence program.
- The relationships among key programmatic variables at the State and local levels.

ANALYSIS OF STATE AND COMMUNITY ACTIVITY LEVELS

Both States and communities surveyed were rated as "active," "in-between," or "inactive" with respect to efforts aimed at meeting the needs of battered women and the same technique for States and communities was used in developing these activity ratings. Individual questions or variables were identified as indicators of activity. The responses to these questions were coded and aggregated to develop a single numerical score for each State and community surveyed. The variables used to develop the score include:

- Whether programs surveyed at the State or community level focus on battered women as a special group.
- Whether programs surveyed at the State or community level have goals pertaining to the needs of battered women.
- Whether programs surveyed at the State or community level provide direct services especially for victims.
- Whether programs surveyed at the State or community level are involved in coordination activities related to the problem of spouse abuse.
- Whether staff or programs surveyed have received training or technical assistance to better understand the needs of victims and their families.

The numerical scores calculated for States and communities were placed on a continuum to determine the range of variation and the clustering of scores. The scores were clustered into three groups distinguishing among active, in-between, and inactive communities or States. Based on the calculations, 15 communities were rated as active, 24 were rated as in-between, and 44 were rated as inactive. These communities were located across 15 States. Within this sample of 15 States, 5 States were rated as active, 5 as in-between, and 5 as inactive. Across all 50 States and the District of Columbia, 15 States were rated as active, 18 as in-between, and 18 as inactive. As with any similar scoring technique, these scores must be considered to be relative, and not absolute, scores.

The relationship between ratings assigned to communities and their respective States were examined using the chi-square test and the Spearman rank order correlation coefficient. An initial analysis of the data reveals no significant relationship between the State and community activity levels; that is, active communities are not necessarily located in active States. The data presented in Table 4-1 illustrate the distribution of communities across States by activity level. The chi-square computed for this table indicates that a statistically significant relationship does not exist between the activity level of a State and that of a community within the State ($p < .05$).

A Spearman rank order correlation coefficient was calculated as another measure of the relationship between State and community activity levels. States and communities* were ranked according to their scores. Table 4-2 displays the corresponding rankings, matching the community score with its respective State. For example, in the State which is ranked highest on activity level, the corresponding community score rank is 13th. In this instance, there was an inverse relationship between activity level of the State as compared to the communities within the respective State. Overall, no distinct pattern emerges. The test results yielded a correlation of 0.240.

Although there is no statistically significant relationship between a State's activity level and the activity level of communities in that State, it should be noted that the activity levels for communities are always lower than those reported for the respective States. To some extent this reflects the difference in opinions and awareness between State level and community level program staff. State level staff may often assume that efforts are being made to serve victims of domestic violence at the community level when, in fact, this is not the case.

ANALYSIS OF STATE FUNDED DOMESTIC VIOLENCE PROGRAMS

The second study issue is concerned with the relationship between the presence or absence of State authorized and funded domestic violence programs and the activity level of DHHS funded programs with respect to victims. Two study questions are addressed by this analysis:

- Across all the DHHS programs, are there differences between the activity levels of DHHS programs in States with a State funded domestic violence program and the activity levels of DHHS programs in those States without a domestic violence program?

- Does there appear to be a difference in activity level, by type of program, in those States with a domestic violence program versus those States without a domestic violence program?

Three activities indicative of a program's efforts to meet the needs of victims were used for this analysis: 1) existence of program goals pertaining to battered women, 2) the provision of direct services especially for battered women, and 3) coordination efforts on behalf of victims and their families.

*The community scores for each State were summed and averaged to arrive at one community score per State.

*The base numbers for all percentages are presented in Exhibit 1.

TABLE 4-1

Distribution of Communities Across States by Activity Level

Activity Level Classification of States	Activity Level Classification of Communities		
	Active	In-between	Inactive
Active	8	7	8
In-between	4	13	21
Inactive	3	4	15

Note: Chi Square = 8.71, $p < .05$

*N = 83 communities located within 15 States selected for the Community Survey; five communities in Michigan are not represented due to insufficient data.

TABLE 4-2

Comparative Ranking of Fifteen States and the Corresponding Communities Within Each State by Activity Level Score

STATES		COMMUNITIES	
Activity Level Scores	Rank	Activity Level Scores	Rank
8.9	15	4.30	15
9.1	14	7.33	1
9.3	13	5.80	7
10.4	12	5.17	12
10.6	11	5.33	11
11.2	10	5.51	10
12.6	9	6.46	5
12.9	8	5.74	8
13.0	7	4.97	14
13.5	6	5.59	9
13.9	5	5.92	6
14.9	4	6.66	3
15.1	3	6.63	4
15.4	2	6.74	2
15.7	1	5.11	13

*The fifteen States are those selected for inclusion in the Community Survey. The scores for the States are derived from data collected for the State Survey. The community scores are derived from data collected for the Community Survey.

Table 4-3 presents the percentage of DHHS funded programs involved in each kind of activity in States with/without a State authorized domestic violence program. The Table 4-3 data suggest that DHHS funded program efforts to help battered women are not related to the presence or absence of a State funded domestic violence program. For example, eight percent of the DHHS funded programs in States with a domestic violence program have goals to assist battered women, whereas 13 percent of DHHS funded programs in States without a domestic violence program have goals to assist battered women. Further, DHHS funded programs located in States without a domestic violence program engage in coordination activities more often than DHHS funded programs located in States with a domestic violence program. A greater proportion of DHHS funded programs located in States with domestic violence programs do provide direct services especially for battered women; however, the differences in level of activity are minimal. Based on this analysis, it appears that the presence of a State funded program is not related to DHHS program activity in the interest of victims.

The Table 4-3 data also were examined on a program-by-program basis to determine whether there is a relationship between the presence of a State funded domestic violence program and the activity level of each DHHS funded program surveyed. No clear pattern of relationships emerges; that is, the presence of a State funded program does not seem to be related to the activities of any particular DHHS funded program. In a few isolated instances, however, there are some fairly substantial differences. For example, Title XX programs appear to be more involved in coordination activities for battered women in States where there is no State funded domestic violence program. Generally though, there are few differences within each of the DHHS programs surveyed.

Because many State funded domestic violence programs are recently initiated efforts, there may not have been sufficient time for them to have an effect on DHHS funded programs. One can also hypothesize that domestic violence programs are more likely to develop in States where the DHHS funded programs are not responsive to victims' needs. Alternatively, a third hypothesis is that where special domestic violence programs are funded by the State, DHHS funded program staff look to those programs to assist victims and use DHHS resources for other problem areas. These issues might be investigated further by advocates of battered womens' services before additional resources are devoted to developing State funded domestic violence programs.

ANALYSIS OF KEY PROGRAMMATIC VARIABLES

Finally, this section examines the relationship among key programmatic variables at both the State and local program levels. A correlation matrix was prepared for both State and community variables to assist in this analysis (see Table 4-4). Several variables are included in the matrix; these variables are considered the key indicators of program activity (programmatic activity level variables), or variables which logically may affect the program activity level (external activity variables).

TABLE 4-3

Comparison of Program Involvement on Behalf of Battered Women in States with/ without a State Authorized Domestic Violence Program

DHHS PROGRAMS	Percent of Programs With Goals to Assist Battered Women in:		Percent of Programs Providing Services Specifically for Battered Women in:		Percent of Programs Coordinating Services for Battered Women in:	
	1) States With Authorized Domestic Violence Program %	2) States Without Authorized Domestic Violence Progam %	1) States With Authorized Domestic Violence Program %	2) States Without Authorized Domestic Violence Progam %	1) States With Authorized Domestic Violence Program %	2) States Without Authorized Domestic Violence Progam %
Aid to Families with Dependent Children (N = 51)	0	3	6	0	25	23
Emergency Assistance (N = 22)	13	21	25	14	38	36
Child Welfare Services (N = 35)	11	12	22	12	56	44
Child Protective Services (N = 46)	7	14	13	17	40	35
Medicaid (N = 48)	0	0	0	3	13	6
Social Services (N = 49)	13	15	38	39	38	58
Community Mental Health (N = 41)	20	13	20	32	30	32
Work Incentive Program (N = 50)	0	0	6	12	19	15
Alcoholism Treatment and Rehabilitation and Alcohol Formula Grants (N = 50)	13	32	25	15	50	59
Drug Abuse Demonstration and Community Service Programs (N = 50)	13	24	38	18	44	56
TOTAL FOR ALL PROGRAMS (N =442)	8	13	19	16	34	36

*The base numbers for all percentages are presented in Exhibit 1.

TABLE 4-4

Correlation Matrix of Relationships Among Program Activity Level Variables and External Activity Variables Across States and Communities

EXTERNAL ACTIVITY VARIABLES	EXTERNAL ACTIVITY VARIABLES										PROGRAM ACTIVITY LEVEL VARIABLES							
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Legislative Status		-.11*		.06	.08						.00	-.20*	-.15*	-.14*	-.14*	-.14*	-.04	.06
2. Program Restricted	-.10*		.13*	.07							.05	-.04	.08	.03	.05	.10	.11*	.04
3. Referral of Battered Women	.08*	.07*																
4. Unmet Service Needs	.11*	.10*	.15		.23*						.21*	-.02	.12	.10*	.17*	.02	.23*	-.15*
5. Outspoken Advocate	.01	.06*	.06*	.16*							.29*	.00	.26*	.26*	.40*	.04	.43*	.28*
6. Domestic Violence Problem in Community	.03	.07*	.24*	.14*	.23*													
7. State Recognition of Domestic Violence	-.08*	.01	.03	-.04	-.02	.09*												
8. Community Recognition of Domestic Violence	-.08*	.05*	-.01	.02	-.01	.13*	.13*											
9. Community Responsibility to Assist Battered Women	-.02	.04	.15*	.08*	.11*	.24*	.03	.00										
10. Adequacy of Community Resources	-.03	.01	-.02	-.06*	.00	-.09*	.07*	.14*	-.07*									
11. Extensiveness of Domestic Violence											.21*	.15*	.25*	.12*	.26*	.26*		
12. State Level Recognition of Domestic Violence											.29*	.04	.11*	.13*	.11*	.03		
PROGRAM ACTIVITY LEVEL VARIABLES																		
13. Focus on Battered Women	-.11*	.09*	-.04	.29*	.11	.27*	.03	.21*	.03		.46*	.58*	.37*	.34*	.04			
14. Definition of Domestic Violence	-.06*	.09*	.02	.07*	.09*	.18*	.17*	.04	.09*		.34*	.43*	.37*	.24*	.13*			
15. Goals for Battered Women	-.09*	.08*	.03	.07*	.18*	.19*	.15*	.05*	.13*		.49*	.51*	.40*	.36*	.18*			
16. Provision of Direct Services	-.02	.08*	.10*	.13*	.24*	.22*	.12*	.07*	.11*		.58*	.45*	.56*	.03	.06			
17. Coordination Activities	.01	.11*	.07*	.18*	.21*	.34*	.11*	.04	.17*		.38*	.25*	.34*	.32*	.15*			
18. Staff Receive Training	.05*	.02	.04	.19*	.25*	.24*	.17*	.06*	.11*		.34*	.25*	.27*	.32*	.30*			

*Matrix above the diagnoal represents those variables analyzed in the State survey; matrix below the diagnoal represents variables in the community survey. A blank space in the matrix indicates that the variable was not collected for one of the surveys.

Note: The symbol (*) within the matrix denotes $p < .05$.

*The base numbers for all percentages are presented in Exhibit 1.

Variables representing program activity include: program focus on battered women, program definition of domestic violence, and program coordination activities to assist victims. Variables representing external factors include status of State domestic violence legislation, presence of advocates within the program, and various respondent opinions about the problem of domestic violence.

The patterns of relationships, presented in Table 4-4, reinforce themes discussed earlier. Program development in the area of domestic violence is in an early phase and has developed in an idiosyncratic manner. Thus, it is not surprising that there are no strong relationships between the programmatic activity level variables and external activity variables. A weak relationship exists between most of the external activity variables and the coordination activity variable (ranging from 0.01 to 0.34). This relationship may result from the fact that some DHHS funded programs lack the resources required to offer special assistance to victims; however, when influenced by external factors, these programs do engage more often in coordination activities to help victims. Coordination activities also often occur through informal mechanisms and require fewer resources and commitments on the part of established programs. DHHS program respondents generally consider coordination with other agencies to benefit victims more feasible than activities requiring special budget allocations.

The correlation matrix does identify a strong relationship among variables which indicate program activity for battered women. This implies that when a program does engage in one type of activity for battered women, it is likely to have other related activites. For example, there is a strong relationship between whether a program provides direct services to battered women and whether the program has defined domestic violence (0.45) or has developed goals pertaining to the needs of battered women (0.56). This pattern exists for both the State and Community Survey data. At the community level, all six of the programmatic variables presented in Table 4-4 correlate strongly with one another. The correlation coefficients range from 0.25 to 0.50, and all are statistically significant ($p < 0.001$). At the State level, five of the six programmatic variables correlate strongly with one another.

Summary

To summarize, the major findings presented in this Chapter are:

- There is no statistically significant relationship between program activities at the State and community levels for battered women.
- Generally, the activity levels of DHHS funded programs appear to be unrelated to the presence or absence of State authorized and funded domestic violence programs.
- Based on correlation analyses, those DHHS funded programs engaging in one type of activity to help battered women are likely to engage in other related activities.

In light of the growing need to make the most use of existing program resources, the data suggest that States and communities may want to examine carefully their strategies for expanding services to victims and their families. It appears that State program administrators perceive more activities occurring on the local level to help victims than are substantiated by this study's findings. State program administrators, perhaps can help local staff become more involved in identifying and assisting victims, while working within the context of their respective programs.

It also appears that where State authorized and funded domestic violence programs exist, or where they are being planned, staff from various State programs need to collaborate further. While State funded programs are filling gaps in the service delivery system, they also may be duplicating some services available through DHHS funded program resources. Study findings suggest that where State funded programs exist, DHHS funded program staff may be relying too heavily on them to meet all the service needs of victims.

Data presented above suggest that once program staff begin to assist victims, other activities follow. Even initial steps taken by staff of DHHS funded programs to deal with the problem of domestic violence may have positive long range effects on improving the delivery of services to victims and their families.

In the next Chapter, major study findings are briefly highlighted as well as their significance on future program development.

CHAPTER 5: STRATEGIES FOR SERVICE DELIVERY

Study findings presented in the previous Chapters indicate that State and local staff of selected DHHS funded programs are beginning to respond to the special service needs of abused spouses and their families. This response is not occurring consistently within or across the DHHS programs studied. Rather, there is considerable variation in activity from State to State and from community to community. The primary reason for this variation appears to be related to staff perceptions of what is or is not within the purview of their program mandate.

In this Chapter, major study findings are highlighted to provide a framework for planning future domestic violence intervention strategies. This discussion includes findings which: 1) have significant implications for future program development, 2) demonstrate steps which staff can take to assist victims, and 3) suggest approaches for increasing State and local staff responsiveness to the needs of victims and their families.

IMPLICATION OF STUDY FINDINGS ON THE DEVELOPMENT OF SERVICE STRATEGIES

This section provides a brief analysis of major study findings which can serve as the basis for planning future strategies to assist victims of spouse abuse.

With regard to the State and Community Surveys of DHHS funded programs, findings show that information is not being collected by staff to document the occurrence of spouse abuse among clients requesting or receiving program services. This may explain why many programs do not have any established procedures to identify victims at either the point of application for services or throughout the service provision process.

When victims are identified by DHHS funded program staff, they typically are referred to other service providers for direct assistance with the problem of spouse abuse. Although not widespead, program staff are more likely to be involved in activities to assist battered women than in activities to assist their children, battered men, or abusing spouses. Special services for these latter groups are virtually undeveloped.

Victims of domestic violence must meet the broader eligibility criteria of DHHS funded programs before they can receive program services. Other victims who do not meet the eligibility criteria established by DHHS funded programs cannot benefit from the services offered by these programs. Ineligible victims typically are those with incomes above the poverty level, those without children, or those who do not exhibit other special problems such as drug abuse.

Staff at State and community levels, in general, recognize spouse abuse as a severe social problem. They also tend to believe that the problem extends beyond the realm of their program mandate. In actuality, the DHHS Federal program mandates do not rule out the possibility of staff taking

special steps to become more responsive to the needs of victims and their families. As evident by the activities already occurring within each DHHS program surveyed, State and local staff have options for emphasis within the program's parameters. The larger issue appears to be that most staff are not aware of, or are not taking advantage of, these options to the benefit of victims. This point is underscored by other study findings. Battered women and their families often have multiple service needs, many of which are currently unmet. The broad range of these needs requires intervention from multiple sources--no one program has sufficient resources to respond in total, not even special programs which target on this population. Thus, the development of strategies at the State and local service levels to make use of all existing resources becomes critical.

The potential of DHHS funded programs to help victims of spouse abuse is recognized by the fact that staff already are active in coordinating their activities with other agencies to benefit victims. Most respondents view coordination of services for victims as the most feasible staff activity in the future. Respondents also consistently identified the need for training or technical assistance to improve the development of a coordinated service delivery network at State and local program levels.

Any effort to encourage DHHS programs to become more involved in assisting victims implies the commitment of resources. Staff consistently pointed out that they are operating with limited financial and staff resources. This reality cannot be overlooked. At the same time, several study findings suggest that DHHS programs do have considerable potential to deal with the problem of domestic violence. First, some DHHS funded programs surveyed have State mandates to intervene with the problem of domestic violence. These mandates have increased staff awareness of the problem, and encouraged the identification of victims and the coordination of services at State and local levels.

Second, State level program administrators tend to report more involvement in activities to assist victims than staff at local levels. State level administrators may be assuming that activity is taking place when it is not. This points to the apparent need for State level administrators to provide further guidance to local staff on possible domestic violence intervention strategies.

Third, in States with State funded domestic violence programs and communities with special programs for victims, there is the tendency among respondents to view these programs as having full responsibility for assisting victims. Although study findings show that domestic violence programs are reducing gaps in the service delivery system and are valuable referral resources to staff working in other programs, the findings also show that most domestic violence programs are struggling financially to remain open. Further, as in the case of DHHS funded programs, no special program has the resources to meet all the service needs of victims and their families. Thus, the need for staff to learn how to supplement one another's program resources to the benefit of victims becomes apparent.

Fourth, the administrative function of the various DHHS funded programs surveyed (e.g., eligibility determination, direct service provision, and/or the purchase of services for clients through contracts with other agencies/vendors) is a factor to consider in analyzing program potential. For example, local AFDC and Medicaid program staff are primarily responsible for processing applications for financial/medical assistance. Therefore, the extent of their potential role in the direct provision of related social/medical services is much more limited than that of staff from the direct service programs surveyed.

Finally, Federal level program involvement with the problem of domestic violence appears to be related to program activity. Generally, programs most active on the State and local levels have received some relevant guidance or assistance from Federal program administrators. These are the Social Services, Alcoholism Treatment and Rehabilitation, Community Mental Health Center, and Drug Abuse Demonstration and Community Service programs.

A REVIEW OF CURRENT SERVICE STRATEGIES

This brief review of study findings on States and communities actively involved in helping victims of domestic violence demonstrates that there are many possible service strategies and approaches to the problem. This review also demonstrates that staff are finding ways to become more responsive to the special service needs of victims, despite the restrictions imposed by limited program resources. Replication of these activities elsewhere to encourage further program development expands greatly the potential for providing help to victims.

As noted earlier, across all DHHS funded programs surveyed, there are examples of staff efforts to identify victims within the broader client population. Once the problem of spouse abuse is verified, these staff encourage the victims to seek services for themselves and for their families. Some programs have hired staff as domestic violence "specialists" to facilitate the service and referral process. A number of programs have provided training to staff to help them become more responsive to the special service needs of victims. Some program staff have established reciprocal training arrangements with staff of domestic violence shelter programs. Staff of DHHS funded programs provide training on elibibility criteria, counseling techniques and referral procedures and, in turn, shelter staff provide training on the dynamics of spouse abuse and methods of intervention.

Some program staff have developed special procedures for responding to the service needs of victims; for example, extending program assistance to battered women residing in shelters, simplifying the application process, and speeding up applications for assistance. Other DHHS funded programs have adopted a family intervention strategy. The family as a unit is considered the "target" of services. Several program respondents noted that the "family" approach enhances their capacity to identify and respond to cases of spouse abuse.

Many staff of DHHS funded programs have engaged in other types of activities to benefit victims. These activities include needs assessment studies on victims, community education, public awareness campaigns, and the establishment of coordination mechanisms to work with and through other agencies to serve victims and their families.

Study findings also show that 16 States have funded special programs for victims of domestic violence. Fifty-five percent of the communities surveyed have grassroots efforts underway to help victims. Some communities have specialized services such as shelter care, peer support counseling, and crisis intervention. Many staff are involved in encouraging Governors, legislators, and other service providers to provide help to victims.

Despite these activities, many communities are without any special services for victims and their families. There remain many victims who are not getting the help they need--even victims living in communities where specialized services exist.

SERVICE STRATEGIES FOR THE FUTURE

One major purpose of this study was to document activities occurring at State and local levels to assist victims of domestic violence and their families. This report has documented these activities, on a program-by-program basis, providing examples for other States and communities to follow. A second major purpose of this study was to identify barriers to service delivery so that resolutions might be sought. This report has cited a range of barriers, pointing out the need for clarification of program mandates and regulations, staff training on various topics related to the problem of spouse abuse, and strategies to increase the application of resources to the problem and the coordination of services. Thus, the framework for developing and improving future service delivery strategies is provided within this report.

Other information not fully tapped by this study could be the focus of future research conducted to support the development of services for victims and their families. There is little information available to describe the following:

- Preventive service strategies.
- Outreach to families of minority groups, including refugees.
- Profiles on both the abused and the abuser, the served and the unserved.
- The short and long-range consequences of domestic violence.
- National, State, and community attitudes about the problem which may interfere with efforts to help the abused and the abuser.

Continued progress in developing better strategies to help victims and their families requires the combined commitment of Governors and State legislators, State and local staff of DHHS funded programs, and staff of special State and locally funded domestic violence programs.

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