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Use of Mental Health Screening Instruments by Non-Medical Helping Professionals: A Needs Assessment

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Abstract

When screening women intimate partner violence (IPV) survivors for mental health concerns, helping professionals must balance the very real concerns that arise with diagnostic labels with the equally real difficulties related to mental health problems. To better understand whether and how mental health screening tools can be more useful in this process, the current study reports findings from an online needs assessment. The nationally representative sample included 325 professionals who work with IPV survivors in United States. Overall, participants have a positive attitude about assessing mental health concerns even though most do not conduct such assessments. From this, the following four areas are highlighted: (a) a need for training, (b) the appropriateness of screening, (c) factors that limit use, and (d) assessment tools. Findings also suggest it may be beneficial to develop instruments and/or protocols that are tailored to the unique needs/experiences of IPV survivors.

Keywords

assessment, domestic violence, anything related to domestic violence, mental health and violence

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Intimate partner violence (IPV) involves the actual or threatened physical, sexual, emotional, and/or psychological abuse by an intimate partner (Saltzman, Fanslow, McMahon, & Shelley, 1999, 2002). To help address the needs of women who have experience all forms of IPV, a wide range of programs and resources have been developed through social service, legal, faith-based, and grass-roots organizations (e.g., Sullivan, 2000; Sullivan & Bybee, 1999). These helping organizations strive to provide wrap-around services, specifically designed to address survivor's needs on many fronts, while ensuring continuity of support. Data suggest that use of such services helps IPV survivors to receive needed resources more quickly and effectively and to subsequently report a higher quality of life (Dutton, El-Khoury, Murphy, Somberg, & Bell, 2005). Although these organizations provide a range of important services to IPV survivors, most are not designed to assess and/or address mental health concerns that often co-occur as a result of prolonged exposure to IPV.

As noted in the literature to be reviewed, women IPV survivors are at an increased risk for developing mental health conditions (e.g., depression, post-traumatic stress disorder [PTSD], and other anxiety related disorders). Thus, screening and subsequent referral for mental health problems has a number of potential benefits. However, there are also a number of potential drawbacks to assessing, diagnosing, and treating women IPV survivors for these conditions (to be discussed below). In addition, most professionals who work with IPV survivors are not trained to assess for mental health problems. For these reasons and others, mental health issues typically have not been a focus within these helping environments. To this end, the following article reports the descriptive-exploratory findings from a nationally representative online needs assessment designed to (a) provide a better understanding about why mental health issues are typically not addressed by front-line IPV helping professionals and (b) further empirical understanding about resources that could be beneficial to these professionals. Participants were helping professionals recruited from social service, advocacy, legal assistance, and faith-based organizations with a primary mission to provide services to IPV survivors in the United Sates (US). This report addresses the perceived need for training and mental health screening tools that non-medical helping professionals can use in their work with IPV survivors. It also addresses the opinions these front-line professionals have about the benefits and limitations of assessing mental health problems with IPV survivors.

Mental Health Sequelae

Included among the mental health conditions that have been noted in samples of women IPV survivors are depression, PTSD, acute stress disorder, and

other anxiety-related conditions (e.g., Golding, 1999; Nathanson, Shorey, Tirone, & Rhatigan, 2012; Warshaw, Brashler, & Gil, 2009; Zlotnick, Johnson, & Kohn, 2006). Likewise, substance use and abuse is a common way to relieve emotional distress and to cope with the aftermath of interpersonal trauma and violence (Golding, 1999; Nathanson et al., 2012). A meta-analysis conducted by Golding (1999) found the weighted mean prevalence of PTSD in IPV survivors to be 63.8% across 11 studies, while the weighted mean prevalence of depression was 47.8% across 18 studies. As well, Golding (1999) noted that the mean prevalence of alcohol abuse across 10 studies was 18.5%, while the mean prevalence of suicidality across 13 studies was 17.9% and drug abuse was noted on average in 8.9% of the samples across 4 studies. Indeed, recent data suggest that multiple, comorbid mental health conditions may be the norm for women IPV survivors who experience mental health symptoms (Beck et al., in press).

Other Lifetime Trauma

All too often, the abuse suffered within an intimate relationship by an IPV survivor occurs in the larger context of other lifetime trauma. For example, children who witness their mothers being abused are more likely to experience IPV as adults (e.g., Wenzel, Tucker, Elliott, Marshall, & Williamson, 2004; Wenzel, Tucker, Hambarsoomian, & Elliott, 2006). As well, numerous studies have linked the occurrence of abuse in childhood (physical and sexual) with IPV in adolescence and adulthood (e.g., Lang, Stein, Kennedy, & Foy, 2004; Stermac, Reist, Addison, & Millar, 2002; Wenzel et al., 2004; Wenzel et al., 2006). Consistently studies conducted with IPV survivors in shelter and clinical settings find high rates of childhood abuse and childhood exposure to parental IPV (Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007). Socioeconomic factors can also expose women to other traumatic events such as violent crime, homicide of friends and family, refugee trauma, sexual assault, and poverty. In addition to direct trauma, more subtle forms of social and cultural victimization can occur due to the IPV survivor's gender, race, ethnicity, sexual orientation, and/or socioeconomic status. These lifetime traumas compound the risk that an IPV survivor will develop mental health related problems (Warshaw et al., 2009).

In addition to the mental health symptoms that could result from exposure to IPV and other trauma, mental health conditions put women at greater risk for being abused by their partner (e.g., Burstow, 2003; Mowbray, Oyserman, Saunders, & Rueda-Riedle, 1998). In one representative study of young adults, 55.7% of the participants who were involved in partner violence had a psychiatric disorder while a third of those who had a psychiatric disorder

were involved in violent intimate relationships (Danielson, Moffitt, Caspi, & Silva, 1998). Similarly, a large national cross-sectional study (n = 4,451) in Australia found that gender-based violence was associated with a number of mental health conditions (Rees et al., 2011). Although these data do not establish a cause-effect relationship, it is notable that rates of IPV exposure and rates of mental health conditions seem to co-vary. Exposure to IPV is particularly concerning for persons with mental illness in that it could exacerbate symptoms, put them at greater risk for a mental health crisis, make it more difficult for them to access needed resources, and increase the abuser's ability to exert power and control over them.

The Conundrum of Diagnostic Labels

When considering mental health symptoms in women who have experienced IPV, a conundrum arises. Most professionals who work to prevent, treat, and otherwise end family violence know the importance of not labeling IPV survivors as "crazy." Abusers can use the stigma associated with mental health–related diagnostic labels to control the IPV survivor, undermine them in custody battles, and discredit them with friends, co-workers, family, police, and the courts. Asserting that abuse accusations are delusions, lies, or otherwise unreal is a key component of the coercion, power, and control used by abusers (e.g., Pence & Paymar, 1993; Shepard & Pence, 1999; Stark, 2007). Labeling the IPV survivor has the potential to reinforce their abuser's ability to rationalize their own abusive behaviors (i.e., I had no choice because she's "crazy"). The abuser can also use diagnostic labels to manipulate through threats to commit the IPV survivor to a psychiatric facility (i.e., because you are "crazy" they'll commit you if you do or don't do . . . *fill in the blank*). Thus, avoiding such labels is an important component in protecting the IPV survivor.

On the flip side of this conundrum, equally real problems exist in that (a) exposure to ongoing trauma (such as prolonged abuse) increases the likelihood of mental health symptoms and (b) mental health conditions appear to increase a women's risk of being abused (e.g., Briere, Woo, McRae, Foltz, & Sitzman, 1997; Goodman, Dutton, & Harris, 1997; Goodman, Johnson, Dutton, & Harris, 1997). The conundrum thus becomes a matter of how to address the presence of mental health symptoms and conditions in IPV survivors in a fashion that does not increase the likelihood of negative labeling and stigma. A first step in considering this issue is to examine current opinions and attitudes that are held by professionals working with IPV populations about identifying mental health problems, particularly within advocacy environments, to get a sense of prevailing perspectives in the field.

Stated Problem

Although mental health problems such as PTSD, excessive generalized anxiety, depression, and substance abuse and dependence have been well documented among women IPV survivors (e.g., Golding, 1999; Jaffe, Wolfe, Wilson, & Zak, 1986), these problems are generally not systematically identified by programs designed to advocate for this vulnerable population. Research has documented that early identification of mental health problems, with appropriate provision of referrals for assistance, can make a significant difference in the lives of multiple trauma exposed populations including combat veterans (e.g., Milliken, Auchterlonie, & Hoge, 2007; Seal et al., 2011) and acutely injured survivors of physical trauma (e.g., Klein et al., 2002; O'Donnell et al., 2012; Zatzick et al., 2004). It would follow that similar screening for mental health problems with early intervention appropriate for women who have experienced IPV would be beneficial as well. Unfortunately, little empirical investigation into this area is available. Furthermore, at the current time, most professionals working on the frontlines do not have the educational expertise to differentiate mental health–related pathology from reactions that are expected and typical following exposure to IPV.

Historically, organizations designed to help IPV survivors include involvement from professionals and paraprofessionals with a range of educational backgrounds including criminal justice, law, social work, psychology, medicine, clergy, and other spiritual/faith-based professions. Although each of these professional groups provides important services to IPV survivors, most do not have mental health specific training. For this reason, it is likely they could benefit from tools to assist with the accurate identification of clients who have significant mental health problems. Such tools have the potential to differentiate the general distress that is expected in the immediate aftermath of IPV from more troubling mental health symptoms and thus, to better serve clients. In particular, these environments may benefit from tools that are tailored for their stakeholders. Unfortunately, the currently available body of literature does not articulate the types of tools that service providers would find helpful. A literature search using PsychInfo and Google Scholar identified (a) no empirical articles that address mental health screening in advocacy environments and (b) no research identifying the needs of professionals working in these environments. To fill this gap in the literature, the current study reports findings of an online needs assessment designed to assess the need for training and mental health screening tools that non-medical helping professionals can use in their work with IPV survivors.

Purpose

As previously stated, a need exists in the professional literature to better understand whether and how helping professionals who work with IPV survivors could use mental health screening tools. It is also important to better understand ways to make these tools more useful for helping professionals who work with women exposed to IPV. To this end, the current study addresses the following four research questions:

Research Question 1: What opinion do professionals working with IPV survivors have about the appropriateness of screening IPV survivors for mental health conditions?
Research Question 2: What factors attribute to the limited use of mental health screening instruments with IPV survivors?
Research Question 3: What training do professionals who work with IPV survivors have in how to administer mental health screening instruments?
Research Question 4: Do professionals working with IPV survivors believe a tiered referral/treatment recommendation protocol would enhance the usefulness of mental health assessment instruments?

Method

The current needs assessment used an online Internet survey of helping professionals working in social service, advocacy, legal assistance, and faith-based organizations whose work focuses on IPV survivors. Participation in the study was anonymous with no direct incentive provided. Informed consent was obtained online by electronically requiring individuals to indicate whether or not they consented to participate after reading the IRB-approved consent document. Those not consenting were directed to a thank you screen and out of the survey site. Those who did consent were directed to the survey instrument. The University of Memphis Institution Review Board approved the procedures for this study (Approval #2266).

Participant Recruitment

Participants were recruited through a mixture of invitation and snowball sampling. First, professionals working in social service, advocacy, legal assistance, and faith-based organizations whose work focused on IPV survivors were invited to complete the needs assessment via email addresses found on publically available websites of various professional organizations.[1] Participants were informed that the purpose of the study was to determine the

need for mental health screening tools that non-medical helping professionals could use when working with women exposed to IPV. They were also informed that the findings would be used to guide the development of instruments and/or protocols that may improve the ability of helping professionals to screen for mental health related concerns.

From these original invitations, snowball sampling was used to broaden the sample. Snowball sampling is a form of chain sampling where study participants recruit additional participants from among their acquaintances (Rubin & Babbie, 2010). To accomplish the second step, participants were asked at the end of the survey to forward the link to their colleagues. In one instance, an organization that received the original email posted the survey on the "help wanted" section of their website.[2] This sampling method was selected to ensure anonymity of respondents and also achieve representation from a wide range of professionals working across the United States. To prevent duplication of responses, the survey program did not allow multiple surveys to be completed from the same IP address. Prior to administration of the survey, the research team decided to only include professionals working in social service, advocacy, legal assistance, and faith-based organizations whose work focused on IPV survivors. Those who did not report to work with IPV survivors would be excluded. The instrument was open for 35 days and received 325 completed responses, all of which met criteria for inclusion.

Participants

Participants for this study include 325 professionals and paraprofessionals working in organizations that provide support to IPV survivors across the United States (including Washington, DC) and the U.S. protectorates. Ages ranged from 24 years to 72 years with a mean age of 44.99 years (SD = 12.52). Demographic makeup of the sample was predominantly female (n = 309, 95.1%) and Caucasian (non-Hispanic; n = 263, 80.9%). Ethnic groups also represented include African American (n = 28, 8.6%), Hispanic (n = 17, 5.2%), Native American (n = 4, 1.2%), Asian American (n = 3, 0.9%), and other (n = 10, 3.1%).

As expected for a study targeting professionals, the sample was very well educated. All of the participants were high school graduates (n = 325, 100%) while most indicated they have a bachelors degree or higher (n = 267, 82.2%). The breakdown of highest degree earned is as follows: high school graduate with no college (n = 1, 0.3%), high school graduate with some college (n = 26, 8%), associate's degree (n = 25, 7.7%), bachelor's degree (n = 98, 30.2%), master's degree (n = 153, 47.1%), doctoral degree (n = 16, 4.9%), and other (n = 6, 1.8%). Participants who selected the "other" option stated they held

the following: (a) a JD (juris doctorate), (c) an ABD (i.e., all but dissertation), (d) master's degree almost complete, (e) nursing, (f) multiple certifications for crisis care and Stephens Ministry, and (g) GED.

Most of the participants worked in not-for-profit organizations (n = 300, 92.3%) with a small proportion working in government (n = 24, 7.4%) and for-profit (n = 1, 0.3%) organizations. These organizations served communities that are primarily rural (n = 132, 40.6%), urban (n = 107, 32.9%), or suburban (n = 41, 12.6%). However, some serve communities that represented a mix of urban/suburban/rural (n = 23, 7.1%), urban/suburban (n = 12, 3.7%), or suburban/rural (n = 10, 3.1%). Participants also had considerable experience working with IPV survivors with an average of 11.51 years (SD = 8.28) and a range from 0 to 37 years. Their professional affiliations included the following: social work (n = 113, 34.8%), administrator (n = 75, 23.1%), psychologist or other professional counselor (n = 65, 20.0%), advocate or activist (n = 56, 17.2%), health profession (n = 6, 1.8%), legal profession (n = 7, 2.1%), paraprofessional (n = 4, 1.2%), and pastor, rabbi, or other spiritual leader (n = 1, 0.3%).

Survey Design

The instrument designed for this study consisted of demographic information and a needs assessment. Demographic questions elicited information about the participant, their place of employment, and the capacity in which they work with IPV survivors. The needs assessment portion was written to specifically address the research questions and included a variety of question types (e.g., yes/no, multiple-choice, multiple-response, and open-ended). Administration of the instrument utilized branch logic to direct respondents to different questions depending on the information they provided to previous questions. The resulting survey flow provided pathway questions tailored to the respondent's unique experience working with mental health assessment instruments. Empirical testing of the psychometric properties of the needs assessment portion of this study was not conducted prior to administration. Even so, a number of evaluative research textbooks point to evidence of reliability, validity, and sensitivity of questions designed to address specific needs such as those included in this study (e.g., Bloom, Fischer, & Orme, 2009; Grinnell & Unrau, 2011; Orme & Combs-Orme, 2012; Rossi, Lipsey, & Freeman, 2004).

Administration of this needs assessment used a for-profit online survey software program (Qualtrics) that is licensed by the institution that employs two of the authors. The program provides state of the art features to build and distribute surveys online. Among these is the ability to build panels to

electronically email potential participants. It also has security features that far exceed those of other survey programs including an anonymous survey function that was activated for this study.

Findings

Research Question 1: What opinion do professionals working with IPV survivors have about the appropriateness of screening IPV survivors for mental health conditions?

To address the first research question, participants were asked whether or not they (a) use mental health screening instruments in their practice and (b) believe standardized mental health assessment instruments could help them better serve women exposed to IPV. Most of the participants' reported that they do not use standardized screening instruments to assess mental health issues with their clients who are IPV survivors (n = 281, 86.5%). Of these, most also believed that the use of standardized screening instruments could help them to better serve their clients (n = 218, 77.6%). Likewise, of the small group who did use standardized screening instruments to assess mental health issues (n = 44, 13.5%), most also believed these instruments do help them to better serve their clients (n = 40, 90.9%). Thus, most of the total sample reported positive opinions about the usefulness (or potential usefulness) of using mental health screening instruments with the IPV survivor population (n = 258, 79.4%).

Participants were then asked three opinion questions about (a) their perceptions of the prevalence of mental health problems within the population of IPV survivors they work with, (b) the impact of these problems, and (c) whether or not their agency should screen for mental health problems. Included in Table 1 (Questions A, B, and C) are the questions asked and descriptive statistics for participant responses. To highlight, most of the participants report the IPV survivors they work with demonstrate behaviors or symptoms that could be attributed to mental health problems "*most of the time*," "*almost always*," or "*always*" (n = 271, 83.7%). Similarly, very few of the participants believe mental health concerns are "*almost never*" a problem or "*never*" a problem (n = 2, 0.6%). However, participants gave less clear opinions about whether or not their agency should screen for mental health–related concerns: a majority reported "*maybe, it depends*" (n = 159, 48.9%) or "*yes, most certainly*" (n = 126, 38.8%) and a minority reported "*no, absolutely not*" (n = 28, 8.6%) or "*I have no opinion*" (n = 12, 3.7%).

Cross-tabulations were used to compare the groups who reported using standardized assessment instruments to assess mental health issues with IPV

Table 1. Survey Questions and Sample Responses.

A. How often do the IPV survivors you work with demonstrate behaviors/symptoms that could be attributed to mental health problems such as depression, anxiety, posttraumatic stress disorder, and/or substance abuse?

	Never	Almost Never	Rarely	Sometimes	Most of the Time	Almost Always	Always	Do Not Know
Use (44)	0% (0)	0% (0)	2.3% (1)	6.8% (3)	31.8% (14)	43.2% (19)	13.6% (6)	2.3% (1)
Do not use (281)	0% (0)	0% (0)	0% (0)	13.9% (39)	37.7% (106)	39.9% (112)	5.3% (15)	3.2% (9)
Total sample (325)	0% (0)	0% (0)	0.3% (1)	12.9% (42)	36.9% (120)	40.3% (131)	6.5% (21)	3.1% (10)
$\chi^2(5, n = 325) = 12.479, p = .029$								

B. How much of a problem do you believe undiagnosed mental health conditions are for women who experience IPV?

	Always a Problem	Almost Always a Problem	Often a Problem, But Not Always	Sometimes a Problem, But Not Usually	Almost Never a Problem	It Is Never a Problem	No Opinion Do Not Know
Use (44)	4.5% (2)	29.5% (13)	54.5% (24)	11.4% (5)	0% (0)	0% (0)	0% (0)
Do not use (281)	6.0% (17)	23.1% (65)	52.3% (147)	14.6% (41)	2.5% (7)	0% (0)	3.2% (9)
Total sample (325)	5.8% (19)	24.0% (78)	52.6% (171)	14.2% (46)	0.6% (2)	0% (0)	2.8% (9)
$\chi^2(5, n = 325) = 2.838, p = ns$							

(continued)

Table 1. (continued)

C. Should your agency screen clients who are IPV victims/survivors for mental health related problems (such as anxiety, depression, and substance abuse)?

	Yes, Most Certainly	Maybe, It Depends	No, Absolutely Not	I Have No Opinion
Use (44)	65.9% (29)	27.3% (12)	4.5% (2)	2.3% (1)
Do not use (281)	34.5% (97)	52.3% (147)	9.3% (26)	3.9% (11)
Total sample (325)	38.8% (126)	48.9% (159)	8.6% (28)	3.7% (12)
$\chi^2(3, n = 325) = 15.800\ p = .001$				

D. Do you believe the currently available mental health screening instruments are appropriate to use with women who experience IPV?

	Completely Appropriate	Mostly Appropriate	Somewhat Appropriate	Neutral	Somewhat Inappropriate	Mostly Inappropriate	Completely Inappropriate	Do Not Know
Use (44)	2.3% (1)	22.7% (10)	34.1% (15)	18.2% (8)	9.1% (4)	4.5% (2)	4.5% (2)	4.5% (2)
Do not use (281)	1.8% (5)	5.0% (14)	16.4% (46)	22.8% (64)	11.0% (31)	7.8% (22)	7.8% (7)	32.7% (92)
Total sample (325)	1.8% (6)	7.4% (24)	18.8% (61)	22.2% (72)	10.8% (35)	7.4% (24)	2.8% (9)	28.9% (94)
$\chi^2(7, n = 325) = 34.724,\ p = .000$								

Note. Percentages are based on the row number. Raw *n* is included in parentheses. IPV = intimate partner violence.

survivors and those who do not. Differences between the two groups were found for Question A, $\chi^2(5, n = 325) = 12.479$, $p = .029$, and Question C, $\chi^2(3, n = 325) = 15.800$ $p = .001$. In contrast, no significant differences were noted between these two groups with respect to responses to Question B.

For Question A, comparison of observed versus expected frequencies for the response options indicated higher than expected observed scores for the options "*almost always*" and "*always*" among the subset of participants who used standardized instruments. In contrast, the observed frequency of respondents who indicated "*always*" was lower than expected among those individuals who did not use standardized instruments. In summary for Question C, comparison of the expected versus observed frequency of response options indicated a higher than expected count for the "*yes, most certainly*" response in the subgroup who reported use of standardized instruments, while the response option "*maybe, it depends*" was reported at higher than expected levels in the group who did not report use of these instruments. Reported use of mental health screening instruments coincided with stronger positive endorsement of the measured concept in both instances indicating a significant difference.

Research Question 2: What factors attribute to the limited use of mental health screening instruments with IPV survivors?

To address the second research question, participants were asked one multiple-choice question eliciting their opinion about the appropriateness of mental health screening instruments for use with IPV survivors (included in Table 1, Question D) and two multiple-response questions eliciting their opinions about why standardized assessment instruments are not used by professionals who work with IPV survivors (included in Table 2). Table 1 Question D includes both the question and response frequency to the multiple-choice question. To highlight, the sample had divided opinions about whether or not the currently available mental health assessment instruments are appropriate to use with women who experience IPV. Less than a third ($n = 91$, 28.0%) responded they are appropriate (*completely, mostly*, and *somewhat*) yet about a fifth ($n = 68$, 20.9%) responded they were not (*completely, mostly*, and *somewhat*). Most of the participants reported they were neutral ($n = 72$, 22.2%) or that they did not know ($n = 94$, 28.9%).

Cross tabulations found differences between those professionals who use standardized assessment instruments to screen for mental health issues and those who do not, $\chi^2(7, n = 325) = 34.724$, $p = .000$. In particular, comparison of the expected versus observed frequencies of responses between the subgroups indicated that among the groups that used standardized instruments,

Table 2. Factors That Attribute to the Limited Use of Mental Health Screening Instruments With IPV Survivors.

A. Many non-medical personnel do not use standardized instruments in their work with IPV survivors, why do you think this is the case (you may select more than one choice.)

	% (*f*)Total Sample (325)	% (*f*)Use (44)	% (*f*)Do Not Use (281)
A.1. Non-medical personnel lack sufficient training to use these instruments.	66.2% (215)	65.9% (29)	66.2% (186)
A.2. Standardized mental health screening instruments are complicated and/or difficult to use.	20.9% (68)	20.5% (9)	21.0% (59)
A.3. Screening for mental health concerns may harm the client.	25.2% (82)	22.7% (10)	25.6% (72)
A.4. There isn't enough time to screen for mental health concerns.	25.8% (84)	34.1% (15)	24.6% (69)
A.5. Only medical personnel should do mental health screening.	11.1% (36)	11.4% (5)	11.0% (36)
A.6. My clients do not experience mental health concerns.	0.3% (1)	2.3% (1)	0.0% (0)

B. Significant research indicates women who experience IPV do not receive care for mental health conditions. In your experience, what do you think causes this? (you may select more than one choice.)

	% (*f*)Total Sample (325)	% (*f*)Use (44)	% (*f*)Do Not Use (281)
B.1. The system is designed in such a way that women who experience IPV are discouraged from getting help.	21.2% (69)	45.5% (20)	17.4% (49)
B.2. Women who have experienced IPV have more pressing needs (e.g., safety, housing, employment).	76.6% (249)	79.5% (35)	76.2% (214)
B.3. Women who have experienced IPV undergo enough negative reaction from others; assessing for mental health would stigmatize them further.	37.5% (122)	45.5% (20)	36.3% (102)
B.4. Most of what women experience following IPV is not a mental health problem. It is a normal reaction to a highly stressful situation.	33.5% (109)	45.5% (20)	31.7% (109)
B.5. Service providers are not familiar with the information that is needed.	34.2% (111)	47.7% (21)	32.0% (90)
B.6. The mental health screening tools that currently available are not designed in a way that is appropriate for use with women who experience.	34.2% (111)	34.1% (15)	34.2% (96)
B.7. Women who are experiencing IPV are oftentimes not ready to receive help.	45.8% (149)	47.7% (21)	45.8% (149)

Note. Percentages are based on the row number. Raw *n* is included in parentheses. IPV = intimate partner violence.

the response options "*mostly appropriate*" and "*somewhat appropriate*" were endorsed at higher than expected frequencies, while among the group that did not use standardized instruments, the option "*I do not know*" was endorsed more often than expected.

Table 2 includes the two multiple-response questions and the response frequencies for each answer choice.[3] In response to the first of these questions, most of the participants agreed that non-medical personnel lack sufficient training to use standardized screening instruments (n = 215, 66.2%). Inversely, almost none believed their IPV survivor clients do not experience mental health concerns (n = 1, 0.3%). No differences were found for any of the answer choices in comparisons between professionals who do and do not use standardized screening instruments. In response to the second question, most of the sample agreed that women who experience IPV do not receive care for mental health conditions because they have more pressing needs (e.g., safety, housing, employment; n = 249, 76.5%). Comparisons between the groups of professionals who use standardized assessment instruments to screen for mental health–related problems and those who do not yielded differences for the following two comparisons: "*the system is designed in such a way that women who experience IPV are discouraged from getting help*" (endorsed more frequently by participants who use standardized instruments, relative to those who do not, $\chi^2(1, n = 325) = 17.856$, $p = .000$, and "*service providers are not familiar with the information that is needed*" (endorsed more frequently by participants who use standardized instruments, relative to those who do not, $\chi^2(1, n = 325) = 4.169$, $p = .041$.

Research Question 3: What training have professionals who work with IPV survivors received in how to administer mental health screening instruments?

To address the third research question, participants were initially asked whether or not they received formal training in mental health assessment. Then, the individuals who indicated they had this training were given a multiple-response question listing six types of training and an open-ended "other" response option. Findings indicate that although 40.3% (n = 131) of the participants received formal training in mental health assessment, the majority had not (n = 194, 59.7%). Of those who received formal training, most received it as part of their educational program (n = 108, 82.44%). Others reported to have received mental health assessment training through in-person training seminars (n = 62, 47.3%), university coursework outside their educational expectations (n = 29, 22.1%), online training for specific instruments (n = 29, 22.1%), and correspondence courses (n = 7, 5.3%). Responses

to the other option (n = 8, 6.1%) can be consolidated into the following: on the job (n = 5, 3.8%), in a supervised practicum (n = 2, 1.5%), and no response (n = 1, 0.7%).

Research Question 4: Do professionals working with IPV survivors believe a tiered referral/treatment recommendation protocol would enhance the usefulness of mental health assessment instruments?

To address the fourth research question, participants were asked the yes/no question, "If a tiered referral/treatment recommendation protocol were created to use with these standardized instruments, do you believe such a tool would enhance their usefulness?" The majority of participants' reported "yes" that they do believe such a tool would be useful (n = 277, 85.2%). Of those that used standardized assessment instruments in their work with their IPV survivor clients, 70.5% (n = 31) endorsed this item while of those who do not use such instruments, 87.5% (n = 246) endorsed it. The difference between these two groups met significance, $\chi^2(1, n = 325) = 8.827$, $p = .003$, even though the vast majority of both groups endorsed the potential usefulness of such a tool.

Discussion

The current study reports findings from an online needs assessment designed to better understand whether and how mental health screening tools can be helpful in programs that serve IPV survivors. The sample included 325 helping professionals working in social service, advocacy, legal assistance, and faith-based organizations whose work focused on IPV survivors in the United States. Most were employed in not-for-profit agencies and reported considerable experience working with this population. Overall, the participants had a positive attitude about assessing mental health concerns even though most do not conduct such assessments. Four key issues arise from the findings reported in this article: (a) the appropriateness of screening, (b) factors that limit use, (c) a need for training, and (d) assessment tools. These findings can be used to inform training needs and further research.

Appropriateness of Screening IPV Survivors

Most of the participants of the current needs assessment believe standardized mental health screening instruments could be useful when working with their IPV survivor clients. This is true whether or not the participant used such screening instruments in their practice. In addition, most participants reported

their clients "*demonstrate behaviors/symptoms that could be attributed to mental health problems*" either "*most of the time*" or "*almost always*" (77.2% combined). Another 13.6% believed they "*always*" exhibited such problems. Likewise, most participants believed "*undiagnosed mental health conditions*" are either "*almost always a problem*" or "*often a problem but not always*" (76.6% combined). These findings coincide with the growing body of literature that finds that IPV tends to co-occur with mental health conditions such as depression, PTSD, acute stress disorder, and other anxiety-related conditions (e.g., Golding, 1999; Nathanson et al., 2012; Warshaw et al., 2009; Zlotnick et al., 2006). Although cause-and-effect cannot be dismantled in this literature, it is notable that the experience of violence and abuse at the hands of an intimate partner is associated with an increased likelihood of mental health conditions.

From this, it should not be surprising that very few of the study participants believed their agency should *not* screen for mental health–related problems (8.6%). A little over a third believe they "*most certainly should*" screen for mental health–related problems (38.8%). Interestingly, the most frequently endorsed answer choice was "*maybe, it depends*" (48.9%), which was endorsed significantly more by the subset of participants who currently do not use mental health screening instruments within their daily activities. The reason for this finding could be that a one-size-fits-all approach to working with IPV survivors is simply not applicable. It is important to note that accurate diagnosis of mental health related problems has the potential to help the IPV survivor receive care, reduce symptoms, and improve their overall quality of life. However, if not addressed competently, diagnostic labels also have the potential to result in victim blame, self-blame, and a myriad of other problems. Because advocacy and other social service environments typically do not need to adhere to current privacy laws regarding health and mental health information, incorporation of mental health screening into these environments will necessitate training in safeguards that are needed to reduce some of these potentially harmful outcomes. The current sample appeared cognizant of the two-edged sword that is presented by mental health screening, given that a large portion of the current study's participants expressed caution in light of also identifying that mental health problems are very real concerns for their IPV survivor clients.

Factors That Limit Use

In addition to concerns that arise about diagnostic labeling, a number of other factors may limit the use of mental health screening instruments with the IPV survivor population. Of these, education and training seem to be primary.

Most of the sample (66.2%) endorsed the item "*non-medical personnel lack sufficient training to use these instruments*" while relatively few (11.1%) believe "*only medical personnel should do mental health screening*." Thus, it seems participants have a positive attitude about the need to assess mental health concerns even though most find additional training is required. Interestingly, a quarter (25.2%) of the participants expressed concerns that screening could harm their IPV survivor clients. As discussed previously, when done improperly, mental health screening could increase the risk and distress of the IPV survivor.

In addition to factors that limit the use of IPV instruments, multiple factors also affect the ability of IPV survivors to receive care for mental health conditions. Most of the sample (76.6%) endorsed the item "*women who have experienced IPV have more pressing needs*" (e.g., safety, housing, employment). It is not surprising that professionals who work with this important population believed that immediate physical and safety needs oftentimes overshadow the ability to address longer term health and mental health issues. The realities experienced by women in violent relationships can make it difficult to perform basic self-care, much less address longer term issues. In addition, a large proportion of the sample (45.8%) endorsed the item "*women who are experiencing IPV are oftentimes not ready to receive help*." In work with IPV survivors, readiness and help seeking are common concerns (i.e., Montalvo-Liendo, 2009; Simmons, Farrar, Frazer, & Thompson, 2011). It is likely that reluctance to receive help for the violence and abuse that was experienced may be mirrored by reluctance to address mental health problems. Future research should study motivation for help seeking (broadly defined) in IPV samples, with derivation of potential strategies to make help seeking easier for this vulnerable group.

In addition to the need to address more pressing life concerns, it is likely that women IPV survivors face other barriers to receiving mental health services. Many IPV helping agencies do not have adequate treatment resources available either onsite or through referrals to community mental health resources (public or private). Although outside the current analysis, financial issues such as poverty, lack of insurance, and limited affordable mental health care resources may add to the difficulties women IPV survivors face when attempting to find help for mental health related concerns. Indeed, the inability of women IPV survivors to receive quality care for mental health conditions is an important social and ethical issue within the professional field. Regardless of the setting, improving the ability of helping professionals to screen their clients for mental health symptoms has the potential to not only help them identify problems that need to be addressed but can also identify resources that are needed within their programs and communities.

Need for Training

Findings of this study highlight the need to train professionals who work with IPV survivors about how to screen for mental health concerns. Although many of the participants received formal training (40.3%), the majority had not (59.7%). Of those who received formal training, most received this training as part of their educational program (82.4%) or through in-person training seminars (47.3%). To some, these findings may be surprising because the sample selected is highly educated (52% with a master's or doctoral degree). However, relatively few of the participants were psychologists or professional counselors (20.0%), individuals who would be expected to have this type of information included in their training curriculum. Indeed, most people who work with IPV survivors in this sample were not trained mental health professionals. It follows then that professionals working with IPV survivors could benefit from training/education about mental health issues, when screening is appropriate, how to use screening instruments, and in what way results should and should not be interpreted. The need for formal training is also an important consideration for the development of screening instruments or adaptation of existing instruments that have been used to screen for mental health conditions in other environments. The sample was clear with respect to the need for additional training in this domain.

Assessment Tools

Other factors that limit assessment of mental health problems with IPV survivors may be related to the currently available assessment tools. Slightly more than a third of the sample (34.2%) endorsed the item "*the mental health screening tools that are currently available are not designed in a way that is appropriate for use with women who experience IPV*." The same number (34.2%) endorsed the item "*service providers are not familiar with the information that is needed*." As discussed previously, the current study is the first to specifically address the needs of professionals who work with IPV. From this, it is clear that further research into the appropriateness of currently available mental health assessment tools for use with IPV survivors could be beneficial. Specifically, it is unknown whether these tools are able to differentiate between the general distress that is expected in the immediate aftermath of IPV and specific symptomatology involved with troubling mental health disorders.

Tools that can help professionals in their decision-making concerning mental health symptoms could also be beneficial. The final research question addressed whether a tiered referral/treatment recommendation protocol

would enhance the usefulness of mental health assessment instruments when working with IPV survivors. Overwhelmingly, the study participants endorsed the usefulness of such a resource (85.2%). Even though more participants who do not assess for mental health with their clients endorsed this question (87.5%) than those who do (70.5%), both groups strongly supported the need for a tiered referral/treatment recommendation protocol. This type of resource seemingly could reduce the likelihood of potential harm resulting from the assessment of mental health conditions. It could provide direction for service providers with respect to making sound recommendations for mental health services, when appropriate.

Limitations and Closing

In closing, it is important to address a few of the study limitations. First, the two part anonymous sampling method used for this study makes it impossible to (a) ensure random selection, (b) know how many people received the survey, or (c) follow-up directly with respondents. However, because participants represented a range of professional affiliations and demographic backgrounds, the diversity of the sample provides support for representativeness appropriate for the purpose of this study. Additional research exploring issues of generalization could be useful; for example, are there differences between regions with respect to the acceptability of mental health screening within social service environments? Second, empirical testing of the psychometric properties of the needs assessment portion of this study was not conducted prior to administration. Although a number of evaluative research textbooks point to evidence of reliability, validity, and sensitivity of questions designed to address specific needs such as those included in this study (e.g., Bloom et al., 2009; Grinnell & Unrau, 2011; Orme & Combs-Orme, 2012; Rossi et al., 2004), this limitation is worth noting.

Despite the limitations of the current report, our findings provide valuable insight into areas where further training is needed, ways to make mental health screening more appropriate for IPV survivors, and factors that may limit the ability of IPV survivors to receive care for mental health conditions. The study also highlighted the need for more information about screening tools, and articulated ways that these tools can be more useful to professionals who work with IPV survivors.

In sum, considerable recognition of the importance of mental health conditions among individuals who have experienced IPV was reported in this needs assessment. Previous research has documented that mental health conditions can increase the risk for additional exposure to violence, make the use of social service resources difficult, and increase the abuser's ability to dominate

and control the survivor. There is a need to identify and address mental health conditions within this population. The current online needs assessment provides needed information about the direction for future research on the impact of mental health screening within agencies that serve IPV survivors, with particular sensitivity to the development or refinement of measures, establishment of training programs to facilitate the use of these instruments, and provision of a tiered referral/treatment recommendation protocol.

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Notes

1. All of the websites identified for this study were found on the State Coalition list of the National Coalition Against Domestic Violence (http://www.ncadv.org/resources/StateCoalitionList.php).
2. The National Center on Domestic and Sexual Violence posted the link for 3 weeks (www.ncdsv.org).
3. In addition to the answer choices provided, each question included an open-ended "other" option, which resulted in a large number of detailed responses (75 and 62 respectively) that will be reported in a subsequent qualitative study.

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