

April 18, 2013

Re: 1238 An Act To Improve Professional Training for Licensed Mental Health Clinicians

Dear Senator Patrick, Representative Herbig and members of the Committee.

My name is Julia Colpitts and I am here representing the Maine Coalition to End Domestic Violence to provide information to support LD 1238, An Act to Improve Professional Training for Mental Health Clinicians. In addition to my experience as the Executive Director of MCEDV, I sit on the Maine Domestic Abuse Homicide Review Panel. I am also a Licensed Clinical Social Worker and a former Assistant Professor of Social work at the University of New England, as well as served as an Adjunct Professor of Social Work at Simmons, Boston University, University of Southern Maine and Smith College of Social Work while supervising field placements.

You may be asking yourselves "Why is this issue worth special consideration?

I have worked on the interface of violence, trauma informed care, mental health and child development for my whole career. Like others, I have watched mounting research make a sea change in how we understand the powerful role of violence in the development of mental health and physical health disorders—changing our sense of the etiology of mental illness as well as offering new best practice responses. One of the advantages of being older is that you understand that knowledge is an evolving process over time. I have lived through two such sea changes in my career—one when we discovered that major mental illnesses were not caused by so called "frigid mothers" but were neurobiological disease processes, and the other when we discovered trauma and post-traumatic stress disorder. In both cases, assessment and treatment changed radically for the better. This is another of those sea changes in understanding.

While this bill initially came to implement the recommendations from the Homicide Review Panel in their Report Working Together to End Domestic Violence,

"7. The Panel recommends that mental health licensing boards require continuing education regarding domestic and sexual violence for currently licensed individuals and going forward, require evidence of education and training around domestic and sexual violence prior to initial licensing so that mental health clinicians and supervisors of workers providing care to victims or perpetrators will be able to demonstrate competence within those fields"

It goes beyond the narrow focus of homicide prevention into a wider awareness of the emerging public health dimensions of the problem and a systemic need for additional training in order to respond to this public health crisis, implement the requirements we face in the Affordable Care Act and other best practice mandates, meet the needs of our health providers and others for referrals and to prevent future violence.

I want to assure you that this does not come from an ideological premise. But is firmly grounded in new, practice changing research, related to the very high prevalence and very serious impact of exposure to violence.

I ask that you consider the following facts in your work on this bill:

Domestic Violence is a major public health issue:

The national and the Maine Center for Disease Control and Prevention recognize Domestic violence as a major public health emergency requiring increased attention, funding and best practice intervention to prevent and/or repair the related short and long term negative health outcomes, including behavioral health problems. The Federal Government has crafted multiple initiatives to address this problem, including putting responses to intimate personal violence within the Affordable Care Act.

High Prevalence of adults and children exposed puts many at risk.

There is high prevalence of intimate partner violence in adults' and of children's exposure to violence in the home. The number of people affected and the range of negative health outcomes is much larger than people had been aware and the impact more severe.

Children exposed

"Exposure to violence is a national crisis that affects approximately two out of every three children. Of the **76 million** children currently residing in the United States, an estimated **46 million** can expect to have their lives touched by violence, crime, abuse and psychological trauma this year. " ((Report of the Attorney General's National Task Force on Children Exposed to Violence 2010)

"More than 1 in 4 (25.3 percent) witnessed a violent act...and nearly 1 in 10 (9.8 percent) saw one family member assault another" within the last year. Reports of lifetime exposure to violence were generally about one-third to one-half higher than reports of past-year exposure... *more than one-third of all 14- to 17-year-olds had seen a parent assaulted*". (Children's Exposure to Violence: A Comprehensive National Survey, Department of Justice, 2009)

Adults Exposed:

"1 in 4 women have been the victim of severe physical abuse by an intimate partner while 1 in 7 men experienced severe physical violence by an intimate partner. (National Intimate Partner and Sexual Violence Survey, 2010, Center for Disease Control) **Prevalence in mental health settings**: Victims of violence are disproportionally represented in mental health settings and need screening, referral, risk assessment and trauma informed treatment. "All social workers will work with survivors regardless of their setting or treatment modality" so that capacity building in this area is critical. (LeGeros, Borne 2012)

On average, over half of women seen in a range of mental health settings either currently are or have been abused by an intimate partner. Many have also experienced multiple forms of abuse throughout their lives, putting them at even greater risk for posttraumatic mental health conditions and affecting their ability to mobilize the resources necessary to achieve safety and economic stability. In addition, women diagnosed with severe mental illness are even more vulnerable to abuse throughout the course of their lives.

Children exposed to IPV after their birth were 3 times more likely to use mental health services and had 16% higher primary care costs compared to children of mothers without IPV. (Rivara et al, 2007)

The prevalence of lifetime IPV among women diagnosed with depression was 61.0%, which is approximately twice that of the general population (Dienemann et al. 2000)

Recent research has made strong links between intimate partner violence and risks of serious health and behavioral outcomes—for adults and for children.

There has been an explosion in recent research that documents the negative impact of experiencing or being exposed to family violence—and creates a sea change in the understanding of the etiology and management of physical and behavioral health disorders. This research demonstrates:

The Brain: The neurobiology of the brain is changed by exposure to family violence, particularly for young children, placing them at risk for behavioral health problems. Impact on children: Teicher (2002) has examined the effects of physical and emotional child abuse on brain development including abnormalities in the limbic system, left hemisphere deficits, and a small corpus callosum. Children's behavioral health symptoms can include: Posttraumatic Stress Disorder, Depression, Anxiety, Developmental delays, Aggressiveness

Health and mental health risks:

Childhood exposure: Dr. Felitti's ground breaking research points out the health risks associated with childhood adverse experiences including premature death, and heightened risk of serious health consequences such as heart conditions, diabetes, cancers, suicide, depression and other chronic health and mental health disorders. (Felitti 2009) His work is validated by other research drawing connections between health, mental health and childhood exposure to violence.

Adult experience: "81% of women who experienced rape, stalking, or physical violence by an intimate partner reported significant short or long term impacts related to the

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207-430-8334 www.MCEDV.org violence experienced ...such as Post-traumatic Stress Disorder symptoms". Men and women who experienced these forms of violence were more likely to report frequent headaches, chronic pain. Poor health and poor mental health than men and women who did not experience these forms of violence" (NIPSV, 2010)

"IPV was a precipitating factor in nearly **one-third** of suicides" (Futures without Violence, 2010)

Best practice recommendations are for routine screening, referral and trauma informed treatment responses in health and mental health settings. Institute of Medicine's Recommendation: Screening and counseling for interpersonal and domestic violence as preventive service for women. These best practice recommendations are now included in the Affordable Care Act. However, surveys of mental health practitioners nationally and in Maine, indicate that they are not aware of these practice recommendations and do not implement them routinely. (Institute of Medicine's (IOM) *Clinical Preventive Services for Women: Closing the Gaps* report)

Mental health practitioners are increasingly being asked to assess risk by law enforcement and/or courts or in crisis assessments and are not trained in domestic violence risk assessment, including the ODARA. They also are not usually aware of the link between suicidal ideation and homicide when domestic violence is a factor, or of the need to incorporate evidence-based risk assessment tools in those cases. Screening, referral and risk assessment are important elements of practice. Mental Health clinicians should not operate outside of their scope of practice, (NASW and other professional ethics standards).

Systemic Best Practice: National recommendations for system response are consistent and include:

- Integrate assessment for lifetime exposure to violence and perpetration of relationship violence into behavioral health
- Assess for trauma symptoms and underlying causes for substance abuse/selfmedicating
- Fully protect the confidentiality of victims' health records
- Ensure that behavioral health services are trauma-informed
- Prioritize the creation of integrated services for on-site services and advocacy for IPV in the behavioral health setting
- Promote cross-training and collaboration between behavioral health and domestic violence programs (Futures without Violence, 2013)

Domestic Violence in the Curriculum

'Best practices in domestic violence work have been difficult to implement because of several factors...including the need for greater inclusion of domestic violence content in social work curricula and deeper ongoing dialogue between professionals. The Institute of Medicine identified additional factors that hamper best practices.

...Including accreditation and licensure standards seldom require specific proficiency in domestic violence practice skills." (LeGeros, Bourne 2012)

"Increased education and training lessen students' blaming attitudes and increase positive interventions in domestic violence cases" (Postmus et al 2011)

Why isn't this optional like some specialty training is? Unlike some specialty fields, exposure to violence is so prevalent within mental health clients and such a crucial part of their experience, that all clinicians will encounter this in their normal practices. Screening is essential to identify people at risk and then an appropriate, trauma-informed response must follow to ensure safety and recovery. "Because presentations of domestic violence vary widely, inquiring only when abuse is suspected will miss significant numbers of clients who are at risk. "2004 National Center on Domestic Violence, Trauma & Mental Health)

I would draw your attention to the material in the packets that I have provided that outlines in more detail the collaborative work among stakeholders, including Maine Department of Health and Human Services, Department of Public Safety, the Office of the Attorney general and community agencies and Universities that resulted in this bill. You will also find examples of national basic best practice that is the basis for our working assumptions.

Thank you for your attention to this issue.

Respectfully submitted,

Julia Colpitts