



**Barbara Hart Interview with Linda Osmundson.
CASA, St. Pete, FL.
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CASA (Community Action Stops Abuse) began to offer shelter services to battered women with drug and/or alcohol consumption/addiction and mental health challenges about 8 or 9 years ago.

We had operated previously with the foolish notion that we could screen out women with addictions and mental health problems in our ten minute telephone screening. We discovered that not only were we unable to screen out women with mental health and substance abuse issues but that we may have been screening out women who slurred their words because of injuries, disabilities or diabetes. We were certainly failing to serve large numbers of women who needed our help and that were possibly even more vulnerable than others we regularly served.

CASA staff was fearful of women experiencing mental health and substance abuse problems. We worried about other women working on their sobriety being “triggered” by women who were abusing substances. We worried about the safety of the children. We worried about medical problems. We worried about our own safety and the safety of others. We had lots of prejudices about women with mental health problems. We thought we could understand and predict her mental health problems if we knew the types of drugs she was taking by using our Physician’s Desk Reference.

We initially applied for a local grant that allowed us to hire two staff people who were certified addictions professionals (CAP). There was a huge learning curve for both for shelter staff and the AOD (alcohol and other drugs) staff.

What did we learn?

1. Shelter staff was afraid. Why were we fearful? We had to examine the fears.

Reasons:

- Didn’t know what we were doing.
- Ignorance caused a lot of our fear.

- We were clear that AOD does not cause the violence in batterers, but we believed that battered women who were drunk/addicted were dangerous.
 - Experience showed that addicted women or women with mental health problems women were not necessarily any more dangerous than the rest of the women we served.
 - Experience also demonstrated how battered women's vulnerability to violence increased when they were using AOD intermittently or regularly. We finally realized that addicted women were not much more danger to us but their own safety was definitely compromised.
2. Staff also believed that because residents were drunk or high, they were addicted. We did not consider situational or medical use. Lots of BW self-medicate to deal with fear and/or to drop out of the picture/life of batterer. Sometimes BW use AOD because the batterer makes them use. Sometimes she is forced to be the procurer of drugs. Once he leaves, she may stop using entirely.

We asked on our intake form a question like, "When was the last time you had a drink?" If she told us she had had a drink as recently as the prior evening, we automatically assumed she had a problem. Most of our own staff would fail that consumption test. Yet we do not consider ourselves problem consumers or addicts.

3. We had concern that AOD consuming women might overdose and staff wouldn't know what to do. We worried that mentally ill BW would have a psychotic break and staff wouldn't know what to do. This seemed particularly challenging for night and weekend shifts when few staff/volunteers on duty. Concluded: if she ODs or has medical problems that we don't know how to handle, staff should call 911, as in other similar circumstances. Staff should/could respond to BW who are consuming or are having an acute MH problem to help her. Concluded: CASA staff cannot protect residents from overdosing, wanting to OD, thinking about OD. The woman has to decide. We are there to support her in her decision making and to offer help if she wants it.
4. Our biggest concern was, "What about the kids?" The intoxicated or psychotic behavior of some residents will frighten the kids. "This is a safe place." Kids shouldn't be exposed to this behavior. We reflected that children are frequently/daily exposed to this behavior on TV, neighborhoods, etc. Kids can cope with these behaviors and still feel safe if we teach them the tools.
5. We were concerned that the behavior of AOD-involved/MH-challenged BW would trigger the other women. It may trigger their biases or trigger their fears. It became clear that CASA could not/did not want to meet the standard of "safety from differences" that these biases might suggest. "We are not in

the business of providing safety from people who are unlike me.” CASA does not promise protection from people who are different or with whom some women, including staff, are uncomfortable. MH and addiction are in the public domain. These are normal human health problems.

6. Staff thought that we should become MH providers. When encountering women with MH problems, some would consult the PDR in an attempt to figure out a diagnosis based on the prescribed drugs that the resident possessed. We kept thinking that if we had a list of all her drugs, we’d know what her problems are and perhaps then what to do to help her. We ultimately rejected this approach: Drugs are prescribed for all sorts of things; we cannot know what the problem is by the medications she takes and, we are invading her privacy.
7. There is significant difference between situational depression and clinical/acute/ongoing depression. Of course the women who come to us are depressed. It is human and natural to feel depressed. In fact, it would be unnatural if BW did not feel depressed by the horrific circumstances we face.
8. The women can help staff understand the nature of the problem they are experiencing and engage in strategy development to respond to/handle the presenting and any underlying problem.
9. CASA has experienced lots of problems in hiring/transforming the treatment approach and retaining AOD and MH professional staff for CASA. The “addictions field” is so coercive. “If you don’t do X, you’re going to go back to jail and lose your kids.” Hard for AOD staff to go from coercion to empowerment.

It has been even harder to employ MH staff because we have encountered such arrogance in the MH field. Several of the people we hired were crazy and had already lost their jobs in the MH field. They would try to dictate treatment plans for residents w/o considering CASA’s culture of empowerment. They are generally very medically, clinically based and not empowerment based. They wanted to medicate and diagnose every behavior, assuming, the reason they’re battered is because they have MH problems.”

10. CASA staff has come to understand that residents with MH problems may be at heightened risk for abuse/exploitation/coercion from others, including but not limited to, their partners. We agree that there may be heightened vulnerability. Many in the community treat those evidencing odd behaviors in ways that may also contribute to the risk of abuse, e.g. isolating, ridiculing, and denying services/housing.

11. It may be harder for BW with MH problems to establish stable, independent, violence-free lives both because of their mental health problems and because of the bias/lack of receptivity of social and community services or family/friends to assist them.
12. 90% of sheltered women say that someone in their family has an addiction problem. This high partly because we serve AOD BW now. This is partly because those BW seeking services now are different women than those seeking shelter 20 years ago. Women previously seeking shelter are now looking for non-residential services, POs, etc. We face whole new demographics of shelter seekers; more AOD-involved, MH, long-term poverty, immigrant, less educated. To serve them/advocate for these women requires changes in programs, practice and protocols. 20 years ago they may not have heard of CASA and if they did, we may have refused to serve them.
13. The paranoia of MH-challenged BW may be exacerbated by abuser, but danger is real.
14. Crisis clinical services may be necessary. Staff has learned that one way to abuse a woman is to keep her from her meds, treatment, and de-stabilize her environment. We may have to intervene for BW w/o meds to get her in the MH system quickly. She may decompensate. Sometimes, we must also seek outside crisis/emergency services for women who are AOD-involved. Will take them back in shelter once they get treatment. We offer a built-in case plan. AOD providers are pleased to work with CASA residents because they don't have to figure out where to send BW with kids after emergency treatment. They can send them back to shelter/transitional housing of CASA.

CASA is now farther along in providing services for residents who are AOD-involved.

1. We encourage support groups in community AOD programs/treatment centers; for women only. CASA provides domestic violence support groups in nearly all of the residential and outpatient AOD programs for women in the city.
2. Addictions people have finally learned to screen for DV. CASA staff have persuaded AOD providers that –“If you treat the addiction, DV will not go away. You cannot treat them if they're dead. If your case plan for her addictions problem is going to kill her, you cannot treat her. No good case plan can ignore DV.”
3. Training for CASA folks on how to de-escalate behaviors/psychotic thinking. If a resident says that the walls are crawling with bugs, staff does not challenge her by saying, “No there are not.” Decrease/refocus/de-escalate and bring the woman down from her agitated state.

4. MH staff of CASA helps CASA staff to deal with residents with MH challenges. We do not encourage them to provide MH treatment at the shelter but to make and follow up on referrals.
5. MH staff of CASA is the bridge to the outside MH system.
6. We advocate post-treatment shelter and advocacy services. Some might remain in aftercare clinical programming.
7. CASA helps women make a plan for the care of their children while they are in treatment. CASA cannot keep kids w/o moms because we are not licensed and have no staff to do so. Now more AOD programs offer treatment where kids can reside with their mothers.
8. We do outreach to BW in homeless shelters/programs. CASA was funded by HUD \$ to help BW with MH challenges residing in homeless shelters/facilities. Our local mental health was funded to provide a traveling HOST (Homeless Outreach Support Team) that was great. The teams did a circuit. HOST staff also did counseling with women who happened to be at CASA, before or after using homeless services. It was a nice bridge for women who wanted help but it was defunded.
9. Anyone who works directly with program participants must take a 3 day core competency training. Offer this training to any MH or Addictions person interested. These professionals serve BW better in their own agencies when they understand DV, empowerment principles, etc.

Recommendations:

1. To serve BW experiencing MH problems, shelters have had to increase staff training. It is critical to know how not to escalate a woman in a full blown MH crisis. Occurred before when they not taking women/had no plans for assisting residents with MH problems.

2. CASA needs a better facility for our shelter. Now CASA has housing that is dormitory-like; 6 people in a room. This setting without privacy is harder for women with MH problems. We would like to offer more privacy, especially women with mental health issues.

While a capital campaign is relatively easy for shelter, it is much harder to raise the money for operating expenses. Therefore, we have to plan for on-going operating costs in a larger shelter with more privacy and probably more beds so we can keep some women longer than we are able to do today.

3. If shelters are going to serve BW with MH problems, we have to be willing to change/adopt shelter, services and advocacy to meet the needs of MH-challenged BW.

4. We must be prepared for an increase in the number of BW with MH problems seeing services. The more you open yourself up to women with MH the more come. Our percentage is fairly high.

5. Must hire supportive MH professionals to work with/support shelter staff, to provide direct services to BW with MH problems and to engage in bridging/networking/system reform work. CASA now has 1 funded staff person who is a MH professional. We need 2. We would like one staff person with MH credentials to be based in shelter/transitional housing (to support staff and to do direct services). The other would be doing outreach and building relationships with MH facilities and intervening/advocating with community systems on behalf of BH with MH challenges.

6. We need to get rid of screening mechanisms and shelter rules that create access/accommodation barriers to women with MH and/or AOD problems.

7. We can be upfront about our past mistakes and misapprehensions/inadequate information that the DV program has about AOD or MH issues. Similarly, MH/AOD folks have not dealt with the DV suffered by their clients. We must acknowledge errors and disservice to BW that results from our ignorance. We can move forward to provide revised, enhanced services and advocacy for these BW.

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