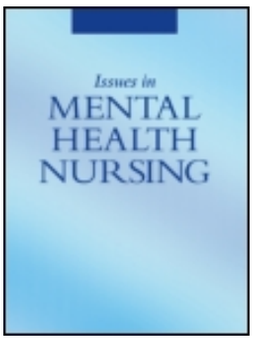

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Domestic Violence in Women with Serious Mental Illness Involved with Child Protective Services

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The purpose of this study is to describe mothers with serious mental illness who have experienced domestic violence and are involved with child protective services. One hundred twenty-two files from the Department of Child and Family Services were reviewed. According to this retrospective review, the majority of the mothers and children had been exposed to domestic violence (62.6%). Mothers with the diagnoses of major depression-single episode and major depression-recurrent were most likely to have disclosed domestic violence exposure, compared to mothers with other serious mental illnesses. Our findings, and that of other cited studies, support the practice of routine assessment of domestic violence in women with serious mental illnesses, identification of safe havens for mothers and children, and access to continuing parenting support for these vulnerable family groups.

The risk and prevalence of domestic violence in adult females with serious mental illnesses (SMI) is serious indeed. In a national crime dataset, Teplin, McClelland, Abram, and Wiener (2005) found a substantially higher prevalence of interpersonal violent crime victimization in women with mental illness than that found in the general population. In a sample of 93 women seen in a psychiatric emergency room, Briere, Woo, McRae, Foltz, and Sitzman (1997) found a large number of incidents of domestic violence including 42% who had been physically abused and 37% who had experienced attempted or completed sexual abuse. In another sample of 153 women who were seen in various psychiatric settings, 64% reported having been sexually assaulted, 36% had been physically attacked, and 24% had witnessed violence (Mueser et al., 1998). Given that women with serious mental illness may be raising children, the concern about the experience or exposure to domestic violence is even greater. The frequency of domestic violence increases the probability of child maltreatment (Bogacki & Weiss, 2007; Ross, 1996). In an effort to describe women with serious mental illnesses who are trying to parent minor children, our study examined child protective services case files that had been cross-referenced with the county mental health board. Our objective was to identify the most frequently emerging characteristics in mothers with SMI and their children, and to determine the incidence of domestic or interpersonal violence.

Domestic violence against adults and children has many consequences, including physical injury, serious cognitive and emotional harm, and considerable health consequences such as fractures, head injuries, genital injuries, and sexually transmitted infections (Campbell, 2002; Jouriles, McDonald, & Norwood, 2001; Paranjape, Sprauve-Holmes, Gaughan & Kaslow, 2009). For the purposes of our study, domestic violence (also referred to as interpersonal, partner, or family violence) was defined as the exposure to and infliction of physical, sexual, or verbal hostilities that place a victim in imminent danger of harm committed by someone with whom the victim has a close, personal relationship (Edleson, Gassman-Pines & Hill, 2006; Holden, 2003). In preparation for our study, the research team reviewed literature that described comorbidities of SMI including domestic violence, parenting problems, the effects of domestic violence on children, and racial/ethnic prevalence of domestic violence.

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LITERATURE REVIEW

Serious Mental Illness and Domestic Violence

In the past decade, researchers have found co-occurrences of SMI and domestic violence. Sheppard (1997) found a 36% incidence of domestic violence in a sample of 116 women with depression. In a small pilot study ($n = 13$) using a qualitative design, Stanley (1997) found links among personality disorders, child abuse, and domestic violence. Subsequently, Stanley and Penhale (1999) reported that all of the mothers with serious mental illnesses in their 1997 study had a history of domestic violence exposure. Although the sample was small and may not have been representative, other studies support similar findings. More recently, McPherson, Delva, and Cranford (2007) found a 19% prevalence rate of partner violence in their sample of 324 mothers with severe mental illness recruited from community mental health agencies and psychiatric units. Also, there were positive relationships between partner violence and age, substance misuse, lifetime number of psychiatric hospitalizations, and the number of psychiatric symptoms. Specifically, the researchers found that partner violence was significantly associated with younger age and elevated drug and alcohol use. Friedman and Loue (2007) conducted a review of 17published studies that examined severely mentally ill women and the prevalence of intimate partner violence. They found that that the risk factors for partner violence included schizophrenia, depression, anxiety, substance abuse, and personality disorders. They hypothesized that those women with impaired reality testing may be more vulnerable to domestic violence due to difficulty in assessing the safety risks in a relationship. Gearon and Bellack (1999) suggested that women with schizophrenia may select relationships that decrease their sense of alienation and isolation with less attention to the interpersonal dynamics that signal danger. Dieneman et al. (2002) found that in a sample of 82 women with a diagnosis of depression, 61% reported a lifetime prevalence of domestic violence. The severity of the abuse was highly correlated to the severity of the depression ($p = .01$). Tolman and Rosen (2001) found that in their sample of women who were receiving public economic assistance that nearly two-thirds of the sample had experienced domestic violence exposure in their lifetime and that they had significantly higher rates of depression than those who did not experience domestic violence in the sample. Another researcher found 68% incidence of major depressive disorder in women who had experienced domestic violence in the past two years (Stein, 2001).

Serious Mental Illness and Parenting

Women with SMI with minor children are more likely to have poor continuity and consistency in their parenting due to the episodic nature of their disorders (Lewin & Abdrbo, 2009). They may be unaware of the effects of their SMI on their children (Mullick, Miller, & Jacobsen, 2001), experience psychotic delusions about their children (Kumar, Marks, Platz, & Yosida, 1995), and have misgivings about their parenting capability (Miller & Finnerty, 1996). The negative effects of depression on parenting have been well documented and include lower attachment security, social-emotional problems, diminished child well-being, lower adaptive functioning, and child behavioral problems (Beck, 1999; Carter et al., 2001; Elgar, McGrath, Waschbusch, Stewart, & Curtis, 2004; Goodman, Adamson, Riniti, & Cole, 1994; Luoma et al., 2001).

Children Exposed to Domestic Violence

There is extensive evidence that children of all ages are found to be affected by exposure to domestic violence. In a sample of infants ($n = 48$) who were reported by their mothers as witnesses of violence in the home during the first year of life, it was found that they exhibited trauma symptoms such as increased arousal, numbing, fears, and increased aggression (Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006). In a sample of 85 preschoolers (25–59 months) who were exposed to household violence, investigators found significant links among child behavior problems, marital violence, higher maternal stress, and impaired quality of the mother-child relationship (Lieberman, Van Horn, & Ozer, 2005). Silverstein, Augstyn, Cabrel, and Zuckerman (2006) found that the combined effects of domestic violence and maternal depression on the kindergarten children in their study were greater than the singular effect of either one. Specifically, the children in the study with concurrent exposure were found to have lower scores in math, reading, and general knowledge, along with poorer self-control and interpersonal skills.

In a review of the literature, Kolar and Davey (2007) reported that school age children who have been exposed to domestic violence have been found to be at-risk for school failure, depression, anxiety, and substance use. In a study that compared 89 adolescents who had been exposed to domestic violence to 96 adolescents who were not exposed, it was found that the exposed adolescents were more likely to replicate the household violence in their interaction with peers, especially those who had been double exposed to violence through parental violence and personal physical abuse (Pelcovitz, Kaplan, DeRosa, Mandel, & Salzinger, 2000). Also, the adolescents in the domestic violence exposure group of the sample had a greater vulnerability for psychiatric disorders, including posttraumatic stress disorder, seasonal affective disorder, major depressive episodes, and oppositional defiant disorder

Race/Ethnicity

Literature that describes racial distribution among domestic violence victims is usually reported along with other contextual and demographic variables. Tjaden and Thoennes (2000) reported higher rates of domestic violence in unmarried, young, African American women who were earning lower incomes. Similarly, black and Hispanic women were found to be at higher risk of domestic violence than white women as well those women between the ages of

18–29 years across all racial/ethnic subgroups (Pearlman, Zierler, Gjelsvik, & Verhoek-Oftedahl, 2003). Interestingly, these investigators suggested that black and Hispanic women were more likely to report to the police because of the perception that police would arrest a black or Hispanic perpetrator. Using data from the 2003 National Survey of Children's Health, researchers found that 10.3% of children live in home with violent disagreements, the most prevalent being within African Americans households (15.1%), urban residents (10.7%), and in parents reporting higher parenting stress (Moore, Probst, Tompkins, Cuffe & Martin, 2007). No studies could be found that examined whether the number of children living in a household was correlated with domestic violence.

Our review of the literature found that the combined effects of maternal SMI and exposure to domestic violence on children can be dire. However, it is not standard practice in mental health care or child protective services within the geographic region of our study to ascertain household violence exposure for women with SMI who are parenting. Current research does not help us understand the possible influence of other factors, such as mother's education, mother's age, or number of children in the household. Our study was interested in trying to address these gaps, particularly in the highest risk families—those where women with serious mental illness are trying to raise their children but are falling short of safe and attentive care. Previous research partially informed the formulation of our research questions.

RESEARCH QUESTIONS

Our research questions were as follows:

1. Does exposure to domestic violence differ by mother's demographics and social characteristics (maternal age at first birth, maternal education, socioeconomic status (SES), number and age of children)?
2. Does exposure to domestic violence differ by mother's serious mental illness diagnosis?
3. What is the relationship between depression and reported exposure to domestic violence among mothers with a serious mental illness?

METHODS

The study was approved by the institutional review board affiliate of the research team. The team collaborated with the Department of Child and Family Services (DCFS) and the Mental Health Board of a large, mid-western city. A retrospective DCFS chart review was undertaken of active files of mothers who had lost temporary custody of their children and who were cross referenced to the mental health board. The DCFS files of women who had permanently lost custody of their children were not considered for the study.

Sample

Women were included if they were mothers and had an Axis I disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association [APA]; 2000), including polysubstance use, bipolar disorder, major depression, schizophrenia spectrum disorders, or dual diagnoses (substance use plus any of the serious mental illnesses) and who were expected to be involved with child protective service for a temporary period. The files of 129 mothers were retrieved; however 7 files were excluded due to insufficient information about the psychiatric diagnoses or the additional diagnosis of mental retardation, thus leaving 122 files in the sample.

Procedures

Data were collected from active child protection investigations at the time of study initiation. The coding forms were given random number identifications to maintain the confidentiality of the participating family groups. The principal investigator and the research assistant double-coded the first 10% of the child protective services files to establish agreement on the definition of the factors and categories. Agreement on factor definitions and modification of the data form were reached by mutual concurrence. Specific income ranges were not available for socioeconomic status, so the data coding was modified using global descriptors of income in nominal categories: adequate (no difficulty meeting basic needs), marginal (some difficulty meeting basic needs), and inadequate (unable to meet basic needs). The researchers used case file descriptors of economic status such as "kitchen cupboards had a variety of canned goods" or "the family had to move due to eviction for non-payment of rent" to categorize income. The types of maltreatment categories typically designated in state and national prevalence rates (physical abuse, sexual abuse, and neglect) were expanded to include combinations of maltreatment types. State protocol for child protective services does not require routine assessment of domestic violence unless it is evident (e.g., facial injury, broken furniture), thus domestic violence was based on self-report of the mothers. Documentation of the specific diagnosis of the mother's mental illness was limited to letters from clinicians and self-report, however, the files were selected for the study by a cross reference of protective services and the mental health board.

Data Analysis

Descriptive analyses, including means, standard deviations for continuous variables, and frequency distributions for categorical variables, were used to summarize the mothers' demographics and major study variables (marital status, race, age at the time of the first birth, number of children, education, global economic descriptors, frequency of hospitalization and outpatient visits in the past 18 months, mental illness type, and exposure to domestic violence). To answer the first and second research questions, chi-square was used to compare within the sample for the nominal categories of demographics and DSM diagnoses. Some of the mothers'

demographic variables were recoded to a smaller number of categories before the analysis (marital status recoded to unmarried = 0, married = 1, race recoded to African American = 0, white = 1, other = 5). To answer the second research question, logistic regression analysis was conducted using mothers' exposure to domestic violence (0 = no domestic violence reported, 1 = domestic violence reported) as the outcome and depression-recurrent as the predictor. All analyses were conducted using SPSS version 16.0 and the *p* value was set at.05.

RESULTS

Subject Characteristics

The majority of the sample was composed of mothers who were single (44.6%), African American (60.2%), and did not complete high school (56.8%) (Table 1). The majority of the sample had no record of having been hospitalized, and 60% of the mothers had used outpatient mental health services in the past 18 months. Nearly 40% of the sample self-reported or had clinical documentation that their serious mental illness diagnosis was part of a dual diagnosis (bipolar, manic and alcohol abuse), followed by those mothers reporting polysubstance use (19.7%). Seven of the files had reports of DSM diagnoses that are not considered as chronic/serious mental illnesses including acute stress, posttraumatic stress, and oppositional defiant disorders. The average age of the mothers at the time of the first birth was 19.6 years (range 14–41 years). The average number of children was 3.8 with a range of 1 to 14 children (Lewin & Abdrbo, 2009).

Exposure to Domestic Violence and Mothers' Demographics

Most noteworthy was the 62.6% prevalence of domestic violence exposure spontaneously reported by the mothers in this sample to the child protective services case workers. The state standards only require investigation by child protective services when domestic violence is obvious, such as visible bruising or lacerations on the mother or child or broken household furniture. Routine questioning about the occurrence of domestic violence or intimate partner violence is not required. Chi-square analysis indicated a nonsignificant relationship between exposure to domestic violence and race or global economic status (Table 2). However, there was a significant difference in exposure to domestic violence and marital status with single mothers being more at risk ($p = .013$). In addition, there was a significant difference in exposure to domestic violence between the mothers' education level ($p = .034$). Thirty-nine percent of mothers who had some high school reported exposure to domestic violence that was significantly higher than those with more advanced levels of education.

TABLE 1
Maternal Characteristics of Women with Serious Mental Illness:

Characteristic	*n*	%
Marital status		
Single	50	44.6
Paramour	24	21.4
Married	20	19.6
Separated	8	7.1
Step-parent	6	5.4
Missing data	10	8.2
Race		
African American	71	60.2
Caucasian	43	36.4
Hispanic/AA & Hispanic	4	3.2
Missing data	4	3.2
Mother's Education		
Some HS	50	56.8
HS diploma	23	26.1
Some college	8	9.1
Less than HS	7	8.0
Missing data	34	27.9
SES		
Adequate	14	13.2
Marginal/Inadequate	66	62.3
Not meeting basic needs	26	24.5
Missing data	16	13.1
Hospitalizations (past 18 Months)		
None	40	50.6
Past 3 Months	3	3.8
Past 4–6 Months	3	3.8
Past 7–12 Months	10	12.7
Past 13–18 Months	20	25.3
Missing data	43	35.2
Out-patient visits (past 18 months)		
None	33	40.2
Past 3 months	6	7.3
Past 4–6 months	13	15.9
Past 7–12 months	15	18.3
Past 13–18 months	9	11.0
Missing data	40	32.8
Exposure to Domestic Violence		
Reported	67	62.6
Not reported	55	38.4
DSM diagnoses		
Dual diagnoses (296.4 & 305.0)*	48	39.3
Polysubstance (304.8)	24	19.7
Combination d/o (not substance abuse)	12	9.8
Others**	8	6.5
Non-SMI disorders***	7	5.7
Missing data	23	18.9

Total files = 122.
*Dual diagnoses: 296.4 Bipolar, manic & 305.0 Alcohol abuse
**Others: SMI disorders with ≤ 4 cases reported
***Non-SMI disorders: acute stress, PTSD, oppositional defiant (Lewin & Abdrbo, 2009)

TABLE 2
Relationship for Exposure to Domestic Violence (DV) and Mother's Demographics

Mother's Demographics	DV(Yes) n (%)	DV(No) n (%)	X^2	P-Value
Marital Status			6.13	**.013**
Married	18 (17%)	3 (2.8%)		
Not Married	48 (45.3%)	37 (34.9%)		
Race			3.05	.218
African American	36 (34.6%)	26 (25%)		
Caucasian	28 (26.9%)	11 (10.6%)		
Others	1 (1%)	2 (1.9%)		
Education			8.68	**.034**
Less Than High School	1 (1.2%)	6 (7.3%)		
Some High School	32 (39%)	14 (17.1%)		
Completed High School	12 (14.6%)	9 (11%)		
Some College (include AD and Post HS trade)	6 (7.3%)	2 (2.4%)		
Socio-Economic Status			1.57	.665
Adequate	7 (7.1%)	6 (6.1%)		
Marginal (Receiving Assistance)	29 (29.3%)	17 (17.2%)		
Inadequate (Threatened Utility Cut-offs)	11 (11.1%)	4 (4%)		
Severe (Not Meeting Basic Needs)	14 (14.1%)	11 (11.1%)		

Exposure to Domestic Violence and Mother's SMI Diagnosis

The mental health diagnoses that were documented in the child protective services case files were used for data collection and analysis. In those case files that indicated that there was a maternal diagnosis of major depression, the researchers based their data coding on copies of clinician letters included in the files and from statements made by the mothers to the case workers who composed the files. In the case of recurrent episodes of depression, the exact number of depressive episodes was not available in the documentation of the diagnosis. Our Chi-square analysis did not find a significant relationship between exposure to domestic violence and mothers with the diagnoses of schizophrenia (any subtype), schizoaffective disorder, depression NOS, or polysubstance use (Table 3). However, there was a significant difference in exposure to domestic violence between mothers who described major depression-single episode ($p = .033$) and major depression-recurrent episodes ($p = .010$).

Exposure to Domestic Violence and Depression-Recurrent

Logistic regression analysis was employed to predict the probability that exposure to domestic violence and depression are associated (Table 4). Depression-recurrent was significantly associated to exposure to domestic violence (Wald $\chi 2 = 5.48$, $p = .019$). The odds of having depression-recurrent episodes was six times as great for mothers who reported exposure to domestic violence (OR = 6.274, 95% CI = 1.35–29.17).

DISCUSSION

The exposure rate of domestic violence in the study mothers and children was 62.6%, slightly higher than Edleson's (1999) report of the overlap of domestic violence and child maltreatment that ranged from 30–60%. The prevalence in our study is similar to that of Goodman, Dutton, and Harris (1995) who found that 69.7% of their sample of episodically homeless women had been physically assaulted. However, this high incidence rate in our study was surprising in that mothers may not be comfortable disclosing their partner or domestic violence. They may fear reprisals from their partner, having their children removed, not being believed, and being stigmatized in their neighborhood or community (Chang et al., 2005; McMurray & Moore, 1994).Women greatly fear having their children removed permanently from their home so they may under-report any perceived family management problems, particularly to human service providers. Thus, the prevalence rate may be higher than that which was spontaneously reported.

In this sample of women with serious mental illness diagnoses who had lost temporary custody of their children, neither race nor global socioeconomic status were significantly associated with exposure to domestic violence. While previous literature (Fantuzzo & Fusco, 2007) has shown that individuals from impoverished neighborhoods have been exposed to higher levels of domestic violence, the current study did not find similar results. Two main factors may have contributed to these findings. First, specific income levels were unavailable in the child protective services files, thus socioeconomic categories

TABLE 3
Relationship for Exposure to Domestic Violence (DV) and Specific SMI Diagnosis

Mother's SMI Diagnosis	DV(Yes) n (%)	DV(No) n (%)	X^2	P-Value
Schizophrenia (any subtype)			.00	.971
Yes	7 (11.9%)	4 (12.1%)		
No	52 (88.1%)	29 (87.9%)		
Schizo-Affective Disorder			1.28	.258
Yes	1 (1.7%)	2 (6.1%)		
No	58 (98.3%)	31 (93.9%)		
Major Depression-Single Episode			4.55	**.033**
Yes	11 (18.8%)	1 (3.0%)		
No	48 (81.4%)	32 (97.0%)		
Major Depression-Recurrent			6.69	**.010**
Yes	17 (28.8%)	2 (6.1%)		
No	42 (71.2%)	31 (93.9%)		
Depression NOS			.11	.745
Yes	16 (27.1%)	10 (30.3%)		
No	43 (72.9%)	23 (69.7%)		
Polysubstance			.47	.491
Yes	45 (76.3%)	23 (69.7%)		
No	14 (23.7%)	10 (30.3%)		

were determined based on qualitative information documented in the DCFS case file and the mothers' self-reports. Given that there was no specific information regarding income level, some measurement error may have been present in assessing SES. Since higher levels of measurement error may have been introduced into SES scores, SES may have been less reliable. When variables have lower reliability (higher levels of measurement error), test results of associations or differences will be attenuated. The second factor is that the current study has a relatively small sample and therefore may be underpowered. The combination of both of these factors may have accounted for the difference in results.

There was a significantly greater risk of domestic violence for unmarried women than their married counterparts; consistent with the findings in a finding in a national study of domestic violence victims (Wallace & Seymour, 2003). Also, women with less than a high school education were found to be at greater risk for domestic violence than those who had completed high school or who had higher levels of education. Our findings are consistent with those of Fantuzzo and Fusco (2007) who examined domestic violence events substantiated by law enforcement across a one-year period. They found a higher proportion of children living in poverty, in female-headed households, where the female head of household had less than a high school education and had experienced domestic violence events than those children living in households at large. Our analysis did not find a significant association between dual diagnosis, the most frequent diagnosis in the sample, and domestic violence. However, clinicians should note that another research team found that children of mothers with substance abuse histories, mental illness, and exposure to violence had an increased risk for emotional and behavioral problems (Van DeMark et al., 2005). We found that a diagnosis major depression with recurrent episodes was significantly related to domestic violence exposure. The greater incidence may be related to the limited cognitive processing that occurs with depression that impairs the mother's ability to identify safety resources and make appropriate decisions in selecting her relationships. Mothers may be fearful of retaliation or escalating partner violence against them or their children if they obtained restraining orders or filed police reports against

Table 4
Summary of Logistic Regression Analysis Predicting the Exposure to Domestic Violence and Depression-Recurrent Association (N = 92)

Predictor	b	SE	Wald χ^2	Odd Ratio	p-value	95% CI
Depression-Recurrent	1.836	.784	5.48	6.274	.019	1.35–29.17

the offender. Additionally, our sample was dominated by compromised economic resources, thus adding to the perception of limited choices for alternative housing to escape the violent partner.

These findings have implications for the health and well-being of the children who are exposed to domestic violence and who are being parented by mothers with serious mental illnesses. Other studies have consistently reported negative consequences for children being raised in violent households or by depressed mothers. Bair-Merritt, Blackstone, and Feudtner (2007) have reported that exposure to interpersonal violence increased risk-taking behaviors in children and were associated with lesser compliance with childhood immunizations. Currie (2006) found that children who were exposed to domestic violence were more likely to have been cruel to animals than children who had not been exposed to this type of violence. Children raised by mothers with mood disorders have impaired attention, disturbed interpersonal relationships, increased rates of psychopathology, and less adaptive functioning (Garley, Gallop, Johnston, & Pipitone, 1997).

Our findings are limited due to the retrospective design and the dependence on self-report to ascertain domestic violence exposure. As discussed previously, DCFS state protocol does not require routine investigation of domestic violence unless it is clearly evident, thus limiting the estimate of incidence to spontaneous disclosures by the mothers. The frequency could have been under-reported by mothers who did not voluntarily disclose or who did not conceptualize contact with their partner as a violent incident. Some of the files included clinician documentation of the SMI and some files did not have DSM diagnostic information from a qualified clinician about the mothers; thus the researchers relied on the mothers' self report of their mental illnesses.

CLINICAL RECOMMENDATIONS

The double impact of exposure to domestic violence and having a serious mental illness is substantial and requires early identification and intervention. Graham-Bermann, Lynch, Banyard, DeVoe, and Halabu (2007) recently tested a ten-week intervention program targeting 6- to 12-year-old children whose mothers self-reported domestic violence. The program was composed of psychoeducational and support groups for mothers and children. The groups for children included support for the children's sense of safety, managing emotions, addressing responsibility for violence, and conflict resolution. A parallel program was provided for mothers, designed to provide support and encourage empowerment along with strategies to improve their repertoire of parenting skills. This ecological approach was found to have small to moderate effects in the children in reducing the children's acting out and aggressive behaviors and improving the attitudes/beliefs that violence is unacceptable in families. Also, the reduction in the children's externalizing behaviors was found to have persisted at the three-month follow-up. Although the study results reported only child effects, the results suggest that interventional programs that involve children and their mothers are effective in reducing some of the negative outcomes of exposure to domestic violence.

Overall, our sample of mothers who had a serious mental illness and who were involved with child protective services were at risk for domestic violence, especially mothers who experienced recurrent depressive episodes, who were single, and had less than a high school education. This triadic composite of impairment suggests a grave vulnerability for these tenuous families that must be considered in developing the service plan. Traditionally, the focus of child protective service has been on the safety of the child, however a family system response that considers safety for the mother who is parenting and overall family safety should be the focus. There are gaps in the coordination of information and care planning between mental health and child protective services that create a formidable barrier to effective services. The gap is further challenged by compliance with protected health information regulations and the inconsistent ability for mental health clinicians and child protective service workers to obtain the necessary HIPAA releases from their clients. Stanley, Penhale, Riordan, Rosaline, and Holden (2003) recommend that "dyads" from mental health and child protective services coordinate assessment and family services. Based on HIPAA compliance, the dyadic roles would need to be explicitly described to the women but would be an asset in the overall case planning and intervention process. The women would benefit from multiple access points to assessment and services via child protective services, community mental health agencies, and the myriad of parenting support offerings. Advance practice psychiatric/mental health nurses could work with other disciplines in designing brief screening checklists for the assessment of co-occuring mental illness and domestic violence as well as more comprehensive assessments. Nurses based in the delivery of women's health care services can press forward in universal brief screenings for depression and domestic violence.

The findings in the study should alert nurses who are practicing in mental health agencies, along with colleagues among DCFS case workers, of the importance of developing a comprehensive family history, assessment of parenting skills, and periodic family safety re-evaluations. Additionally, collaboration is called for between DCFS and advanced practice psychiatric-mental health nurses who provide therapy for women with serious mental illness. Future research should examine the impact of routine assessment of parenting skills and safety in a home where a mother with serious mental illness is raising children.

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