Meeting the Mental Health Needs of Adult Domestic Violence and Sexual Assault Victims: Considerations for Domestic Violence and Sexual Assault Service Providers

Jeff Williams, MPP
Joel Rosch, Ph.D.

Center for Child and Family Policy
Duke University

Bridging the gap between research and public policy to improve the lives of children and families

~ www.childandfamilypolicy.duke.edu ~

Available on the web at
http://www.childandfamilypolicy.duke.edu/Publications/Medicaid6-06.pdf
# Table of Contents

I. Purpose and Outline .........................................................................................4

II. Goals ..................................................................................................................6

III. Victimization and Mental Health .................................................................8

IV. The North Carolina Context ..................................................................13

V. Introduction to Medicaid Reimbursement Process .............................15

VI. Conclusions ..................................................................................................20
ACKNOWLEDGEMENTS

A number of people served as reviewers for this paper and were of great assistance in a variety of ways including fact-checking, providing feedback regarding the usefulness and relevance of the document, and general editing and proofreading.

Margaret Barrett, Orange County Rape Crisis Center
Carol Duncan Clayton, formerly with the NC Council of Community Programs
Elissa Hanson, Access III of the Lower Cape Fear
Lynda Harrison, Center for Child and Family Policy, Duke University
Dr. Sandra Martin, School of Public Health, University of North Carolina at Chapel Hill
Bonnie Morrell, Division of Mental Health, Substance Abuse, and Developmental Disabilities, NC DHHS
Jenni Owen, Center for Child and Family Policy, Duke University
Starleen Scott Robbins, Division of Mental Health, Substance Abuse, and Developmental Disabilities, NC DHHS
Adele Spitz Roth, Center for Child and Family Policy, Duke University
Margaret Samuels, Center for Child and Family Health
Geelea Seaford, Center for Child and Family Policy, Duke University

We would also like to thank Kim Gauss with the Wesley Shelter, and Tom Campbell with Family Services of the Piedmont, for sharing their agencies’ experiences and allowing us to include them in this document.

This report was commissioned by the Z. Smith Reynolds Foundation and is based on their interest in and support for domestic violence and sexual assault agencies and the victims they serve. Thanks to Leslie Starsonenck for help in researching and editing the document.

Jeff Williams, presently an analyst for the FBI and a 2006 Masters of Public Policy graduate, Duke
Dr. Joel B. Rosch, Senior Research Scholar, Center for Child and Family Policy

For questions regarding this report, please contact Dr. Joel Rosch at jbrrosch@duke.edu or (919) 613-9291.
I. Purpose and Outline

This document discusses the provision of services designed to alleviate mental health concerns among adult victims of domestic violence and/or sexual abuse and assault. The purpose of this document is to assist providers of domestic violence and sexual assault services\(^1\) in making decisions about mental health services for their adult clients, and specifically whether to provide these services directly, or through a contractor or another agency. The Medicaid program, because of its complexity and relevance in serving as a vehicle of reimbursement for delivering these services, is discussed in some detail. The authors take the position that for some victims, mental health services are critical for recovery. Further, providers of domestic violence and sexual assault services are accustomed to seeing and helping people manage these symptoms as they work to recover from victimization. These providers, therefore, can often serve as critical points of entry into the mental health system, and as gatekeepers for assuring the quality and accessibility of mental health services.

How and under what circumstances should domestic violence and sexual assault agencies provide mental health services either directly or by helping their clients access these services from other providers? This document gives an overview of North Carolina’s recent mental health system reform efforts and poses some important questions for providers to consider.

In North Carolina, public services for mental health, developmental disabilities, and substance abuse are organized under the same organizational entity at the state level. That entity is the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services located within the North Carolina Department of Health and Human Services. This document focuses on mental health services, rather than on the broader scope of behavioral health services, which includes mental health, substance abuse, and developmental disabilities for adults and children. However, some sources of reimbursement for mental health services are also applicable to substance abuse and/or developmental disability services that domestic violence or sexual assault victims may need.

Outline of the document:

- Section I explains the purpose of the document and provides an outline.
- Section II explains why the authors embrace the goal of ensuring that appropriate, effective mental health services be available to victims of domestic violence and sexual assault, and assumes that domestic violence and sexual assault programs can and sometimes should deliver these services. The more specific question this document poses is whether domestic violence and sexual

---

\(^1\) The term domestic violence and sexual assault providers is used here to refer to the often state-funded community-based agencies that offer a range of services including emergency shelter, hotlines, counseling and advocacy, and community education. Where the term “provider” is used in the document, it is referring to these agencies. For a list of these providers by county, go to www.doa.state.nc.us/cfw/cfw/htm
assault service providers should deliver these services directly through their own programs and agencies or by coordinating with others in their community.

- Section III reviews the histories and perspectives of the domestic violence and sexual assault communities, and the mental health community, as it relates to domestic and sexual victimization and pre- or attendant mental health concerns. It provides background as to the reasons these two communities have not formed easy partnerships, in some instances, and suggests that these obstacles are dissipating with time, trends and an increased commitment to collaboration.

- Section IV describes the current landscape in North Carolina, including recent reforms to the public and private mental health system.

- Section V provides options for effective mental health services models that providers might wish to adopt. A cost analysis of various scenarios is included because it is one of the key considerations facing providers and communities.

- Section VI draws conclusions about some promising models for providers to pursue in order to improve access to mental health services.
II. Goals

In addition to explaining some of the mechanisms involved in North Carolina’s mental health system, the authors begin with the assumption that providing access to mental health services to victims of domestic violence and sexual assault is a desirable goal. Not all providers agree with this, as discussed in Section III. Below is a brief discussion of why providing these services directly to persons victimized by domestic or sexual violence, or, arranging for the delivery of these services, is a stated goal within this document.

➢ There is significant evidence that victimization occurs across the lifespan and that persons that suffer abuse throughout their lives are at higher risk for developing mental illnesses that can interfere with their functioning.2 In many cases, depression, anxiety, and other symptoms related to Post Traumatic Stress are linked to victimization. In addition, serious mental health concerns can pre-date victimization and often exacerbate the symptoms. This may include any biological predisposition to mental health illness. Women may enter domestic violence or sexual assault programs without having received treatment for conditions such as bi-polar disorder, schizophrenia or other serious and persistent mental illnesses.

➢ North Carolina-based research on the co-occurrence of mental health and victimization suggests that domestic violence and sexual assault programs are relatively ill-equipped to respond to their clients’ mental health and substance abuse needs. The 2001 study found that a majority of domestic violence service providers reported that at least 25 percent of their clients had mental health problems. In addition, more than half said that less than 25 percent of their staff had formal mental health training, and less than a quarter (23 percent) of the programs had an agreement with their local mental health center.3

➢ It is important that domestic violence and sexual assault providers with their particular expertise, perspective, and commitment to their clients, ensure a local


inventory of high quality, accessible, and culturally-appropriate mental health services. North Carolina’s mental health system reform represents opportunities to do that. It is especially important in communities where domestic violence and sexual assault victims are not a clear part of the mental health delivery system, as reflected in the local plan developed by the Local Management Entity, as described in Section IV.

- Some programs, including Medicaid, as discussed in Section V, are specifically designed to benefit low-income persons. Domestic violence and sexual assault cut across all socio-economic levels. There is evidence, however, that a significant percentage of domestic violence and sexual assault service providers’ clients are low-income women, many of whom are eligible for Medicaid.

- Billing Medicaid may serve as either a revenue-generating or revenue-neutral undertaking, causing providers to be less reliant on time-limited funding, including federal, state, and local government grants. Similarly, having these services available in the community can allow providers to focus their resources elsewhere.

- While confidentiality and privacy must remain a priority, recent developments in public policy -- most notably HIPAA, the Health Insurance Portability and Accountability Act -- may alleviate some of the fears providers have about their clients being at heightened risk of detection by their offenders when they begin receiving mental health services. In addition to becoming familiar with the protections that exist, it may be worthwhile for programs to distinguish between clients that require a high level of security and confidentiality for purposes of safety from those that may not, in order to enhance access to mental health services. For example, victims of domestic violence who are in hiding likely require a higher level of security and secure record keeping than clients who were childhood victims of sexual assault. Services for the former group might be paid for with funds that demand less record keeping and information sharing than some public sources of funding.

Confidentiality, cost, and bureaucracy can present challenges to providers as they consider meeting the mental health needs of their clients. Fortunately, there appear to be ways to overcome many of the challenges, as later sections of this document describe.
III. Victimization and Mental Health

Philosophy

Historically in North Carolina and across the nation, there has not been an easy alliance between the domestic violence and sexual assault advocacy communities and the mental health system. Among the explanations for this unease are:

- For domestic violence and sexual assault service providers, “victimization” is the presenting problem. For mental health service providers, the focus is on the symptoms that the person presents that may or may not stem from victimization, and how to alleviate those symptoms. In general, domestic violence and sexual assault advocates believe that victimization is the overriding influence on the victim’s current functioning. In fact, depression and anxiety are often viewed as normal responses to victimization, rather than an indication of poor mental health. Mental health providers often place less importance on why the person is experiencing symptoms and focus on how best to alleviate symptoms and increase the person’s functioning.

- Many domestic violence and sexual assault advocates believe that “victim-blaming” or assigning victim culpability or complicity in their victimization continues to fuel victimization rates. This history of society’s misguided mindset of victims causing their own victimization – whether domestic violence or sexual assault – extends into the mental health tradition as well, with Freud’s assessment of women who were suffering from victimization as hysterical and/or narcissistic. Some advocates are still leery of a profession that might assign responsibility or blame to the victim.

- Part of the tension between domestic violence and sexual assault service providers and mental health service providers stems from the myths and stereotypes associated with each; there is a great deal of shame still associated with being identified as a “victim” and/or as “mentally ill,” and while providers may not believe these stereotypes, they cannot help but be influenced by them.

- Perhaps the greatest concern shared by advocates is that the victim will be viewed as culpable in her own victimization and/or is so traumatized as to

---

interfere with her emotional or other functioning, and that she will be penalized in a variety of ways for either or both scenarios. Prominent among the feared punishments are jeopardizing her status as a parent (in court or in the public child protection system), and/or undermining her credibility as a witness in a criminal prosecution or civil litigation against the perpetrator of the violence.

➢ To some degree, domestic violence and sexual assault service providers believe that restoring a victim’s physical and emotional safety will improve mental health and substance abuse symptoms and concerns. Evidence to support this claim is mostly anecdotal. For example, women have been known to self-medicate as a way to numb the effects of abuse and to stop using substances once they exit the relationship. In the case of mental health symptoms, feelings of anxiety and depression, for example, may decrease as recovery is under way. For some persons, however, symptoms may be more serious (i.e. a major mental illness), or they may persist or worsen.

Mental health clinicians are less optimistic about the sweeping effect restoring physical safety has on a person’s mental health. Although removing the victim from the oppressive and violent situation might be seen as an important goal, clinicians often do not share advocates’ optimism that this alone will ameliorate what has happened to the individual’s psyche over long periods of abuse, including changes to brain chemistry; the way the abused individual views the world and society; and the way the individual functions. In fact, many researchers have likened domestic violence survivors to torture survivors. Cognitive behavioral interventions have shown some progress in this area and rely more on reducing current trauma symptoms and changing “cognitive distortions of the self” as opposed to traditional psychoanalysis.

➢ Lastly, domestic violence and sexual assault advocates are deeply committed to offender accountability. Misdiagnosing battering behavior as antisocial personality disorder or explosive disorder might undermine that goal and lead to distrust of the mental health field.

Some of these philosophical beliefs have been challenged or have shifted over the past decade for a variety of reasons including: domestic violence and sexual assault service providers becoming more organized along traditional services, including providing services out of a so-called Family Services model; innovation among providers [see Side Bar for a description of the Elizabeth Stone House program in Massachusetts]; an emphasis on forming multiple partnerships in the community; and a focus on providing comprehensive services.

---

5 Judith Herman, Trauma and Recovery.
Changes in the Mental Health Field to Assess and Address Traumatic Victimization

Historically, victimization and the effects of trauma have not been a routine part of formal training or practice by mental health providers. Specific training on assessing victimization and tailoring interventions accordingly has not been a routine part of higher education in preparation for careers in social work, counseling, or clinical psychotherapy. In addition, training about how these forms of victimization interact with major mental illnesses, i.e., psychoses, bi-polar disorder, borderline personality disorder, and clinical depression, has been generally inadequate. Finally, there have been limited examples of evidence-based clinical interventions for ameliorating trauma in adults, and, fewer still, designed specifically for sexual assault or domestic violence assault survivors. Because of the nature of victimization, this lack of training or perspective has resulted in not only ineffective, but in some cases, harmful practices. The most notable examples are the use of some forms of “couples’ therapy,” which assumes shared responsibility in domestic violence cases; and a lack of understanding or exposure to Rape Trauma Syndrome, in the case of sexual assault. However, in both areas of education and training of clinicians, and the development of evidence-based practices to address trauma, there are monumental changes afoot.

As a result of the mental health needs that emerged from the September 11, 2001 terrorist attack in the United States, and a number of unprecedented natural disasters, including hurricanes and flooding, the concept of trauma has received more attention. A formal response to trauma emerged with the establishment of the National Child Traumatic Stress Network in 2001. Its mission is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States. It considers multiple types of trauma, including terrorism, natural disasters, domestic violence, sexual abuse, and physical abuse, and neglect as part of its scope of concern.

---

6 Rape Trauma Syndrome (RTS) was first identified by Ann Wolbert Burgess and Lynda Lytle Holmstrom in 1974, and is commonly known as a cluster of emotional responses to the extreme stress experienced by the survivor during a sexual assault.
With some exception in nursing and law schools, domestic and sexual violence have traditionally been the domain of university women’s studies departments and other social justice courses. With an increasing interest in various types and effects of trauma, including domestic and sexual violence, it is likely that clinical or counseling courses of study will increasingly address these forms of victimization and related effects for adults and children.

More and more domestic violence and sexual assault agencies are hiring professionals with formal education, training, and experience in addressing mental health symptoms. This trend, sometimes called “professionalization,” has increased expertise within some agencies and programs. Currently, most state and federal sources of funding for domestic violence and sexual assault services do not require grantees to deliver mental health services, but do require that programs make arrangements for their clients needs to be met in this regard as part of the programs’ community partnerships.

Confidentiality of Communications and Recordkeeping

The importance of confidentiality in the domestic violence and sexual assault advocacy communities is of paramount importance for two primary reasons. The sexual assault movement, in particular, has fought for communications between victims and those in
the position to assist them\footnote{In some states, “privileged communication” legislation has applied to a variety of groups including clinicians, therapists, advocates, counselor, or lay persons. In 2001, North Carolina passed legislation designed to govern communications between agents of sexual assault and domestic violence programs. See http://www.ncga.state.nc.us/Sessions/2001/Bills/House/HTML/H643v6.html for the text of the bill.} to be protected primarily in the legal arena. Of equal importance and concern for sexual assault and domestic violence advocates has been strict confidentiality for the purposes of enhancing a victim’s physical and emotional safety from acts of stalking and harm. Dignity, privacy, and respect for individuals who are often reluctant to disclose victimization also play a key role. Consequently, detailed record keeping and billing by insurance companies have been traditional causes for concern by the domestic violence and sexual assault advocacy communities, in part because of the potential for security breaches and the additional concern of releasing information to perpetrators who may use the information to locate victims. Also, in cases where there is a legal dispute in the courts, including custody for children, these records can be subpoenaed and used in court. While in some case this may prove beneficial to the victim, it is important to be aware of the level of exposure.
IV. The North Carolina Context

Mental Health Reform

The first major reform of North Carolina’s mental health, developmental disabilities and substance abuse services system in more than 30 years took place in 2001 in response to the passage of House Bill 381. This legislation called for sweeping changes and reforms in the service delivery system over a five-year period. Area authorities or county programs have or are in the process of divesting their role as service providers to become Local Management Entities (LMEs) that contract directly with providers for services needed in the community. These Local Management Entities are responsible for managerial functions such as general administration, business management and accounting, information management and analysis, provider relations and support, screening/triage/referral, service management, consumer affairs/satisfaction, quality management, and outcome evaluation.

Domestic violence and sexual assault service providers should, along with their community partners, gather accurate information about what is occurring within the communities they serve and conduct an audit of accessible, effective, available, and culturally-specific mental health services for victims of domestic violence and sexual assault with the LME as their community partner.

How is the Mental Health System Funded?

Funding to support these community mental health services comes from a combination of sources, including private insurance, Medicaid, county funds, state funds, and federal funds. The North Carolina Department of Health and Human Services (which houses the Division of Mental Health/Developmental Disabilities/Substance Abuse Services and the Division of Medical Assistance) contracts with each Local Management Entity. The State monitors the Local Management Entities’ compliance with contract requirements. Local Management Entities are responsible for monitoring their contracted providers of services. A list of the Local Management Entities is available at http://www.dhhs.state.nc.us/mhddsas/lmedirectory.htm.

Who can receive what services?

Policies regarding state funds and federal grant funds available to Local Management Entities to support the delivery of services require that these funds be used to serve specific “target populations” (See http://www.dhhs.state.nc.us/mhddsas/iprsmenu/ and click on “target populations” for detailed information). Policy also requires and outlines the specific services supported by state and federal grant funds that can be made available to each target population (click on “service array” on the web page identified above).
STATE PLANNING FOR THE MENTAL HEALTH NEEDS OF DOMESTIC VIOLENCE VICTIMS AND THEIR CHILDREN

It is worth noting an important initiative underway in North Carolina related to domestic violence and mental health. As part of 2003 domestic violence legislation, the North Carolina legislature directed the Department of Health and Human Services to “study and develop a plan for serving clients of domestic violence programs with mental health and substance abuse service needs.” Stemming from a work group’s recommendations, the Department developed a plan that focuses, as directed by the legislation, on diagnostic and referral services for any client in a domestic violence program suspected of having a mental illness or substance abuse problem. It also addresses the delivery of appropriate services to clients meeting the target population criteria, as defined in the State Plan for mental health. The plan also addresses the delivery of services to children identified through domestic violence programs. The plan includes recommendations for how to achieve these goals. As of this writing, the study has not been formally presented to the NC General Assembly and therefore has not been publicly distributed.

When mental health, developmental disability or substance abuse services are being sought from an LME, contact should be made with the access/screening unit of the LME in which the individual is seeking services.

What should a domestic violence or sexual assault service provider know about providing these services?

If domestic violence and sexual assault service providers are considering providing services that are supported by state funds, federal grant funds, or Medicaid, the agency should contact the LME provider relations unit to get additional information about the requirements for becoming a provider of specific types of service.

The Council of Community Programs is the trade association for Local Management Entities. Each LME is a member of the association, through which it receives legislative advocacy, resources and technical assistance, and relevant policy changes. The Council’s web address is http://www.nc-council.org and contains a listing of statewide RFPs, contact information for LMEs, notices of training seminars, relevant policy information for provider relations with LMEs, and an email listserv for provider support.
V. Introduction to Medicaid Reimbursement Process

This section provides information regarding the process for becoming a Medicaid-approved provider to deliver mental health services directly.

How can I arrange to provide mental health services directly to my clients and receive reimbursement?

Medicaid only pays for services that are provided to individuals eligible for Medicaid coverage.

To receive Medicaid reimbursement for mental health services, the service provider must enroll with the Division of Medical Assistance as a Medicaid provider. Medicaid reimbursable outpatient services include assessment, treatment (individual medical evaluation and management, including medication management, individual and group therapy, behavioral health counseling), family therapy, and psychological testing for recipients of all ages. For the policies that apply to these outpatient services, refer to the Division of Medical Assistance Clinical Coverage Policy at http://www.dhhs.state.nc.us/dma/bh/8C.pdf

For information about the requirements for enrolling as a Medicaid provider, individuals should contact the local LME provider relations unit. Additional information about the process for endorsing providers for services that may only be provided by a provider agency are at the Division of MH/DD/SAS web site, http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/provendorse.htm (See Communication Bulletin # 044). Different policies apply for practitioners who may be independently enrolled by Medicaid.

The Division of Medical Assistance also has detailed information about policies and requirements related to mental health, developmental disabilities, and substance abuse services on its web site (see http://www.dhhs.state.nc.us/dma/ and click on Mental Health Reform).
Protecting Client Confidentiality

Domestic violence and sexual assault service providers use a number of strategies to ensure client confidentiality, some mandated by various funding sources and others learned through years of experience. HIPAA8 (the Health Insurance Portability and Accountability Act of 1996) is the governing legislation on confidentiality and privacy in the mental health field. In addition, the North Carolina Division of Medical Assistance has administrative regulations on protecting client confidentiality9 that address such topics as penalties for failure to comply with the regulations, ownership of records, and releases of information/consent.

Cost-benefit Analysis

As part of determining the most appropriate model of service delivery, domestic violence, and sexual assault providers should have an understanding of the costs of supplying and billing for mental health services. The scenario below outlines costs associated with hiring professional staff that would apply to a North Carolina domestic violence and sexual assault service provider. This scenario differs substantially from the one in which an agency would seek endorsement and certification as a Medicaid-approved provider.

Hiring professional therapy staff entails several costs -- payroll, employee benefits, taxes, and time spent on paperwork. On the other hand, paying for full or part-time on-site professional staff can significantly enhance an organization’s mental health services and can potentially pay for itself through reimbursement funding. The following section provides a hypothetical cost analysis. Due to variability across organizations in the areas of sliding fee scales, client socioeconomic status, numbers of eligible clients, services provided and client payment methods, providers should rework the formula presented below to most closely fit their organization. The cost-benefit analysis provided in this section is designed to estimate the financial impact an agency might expect from hiring professional staff to deliver mental health services reimbursable with Medicaid funds.

Projected Costs:

Costs associated with employing professional services can vary depending on existing staffing levels and expertise, but generally include wages/salaries, employee benefits, and payroll taxes.

8 The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

9 The rules can be found at http://www.dhhs.state.nc.us/mhddsas/manuals/aps/apsm45-1confidentialityrules.pdf
Using data from the Bureau of Labor Statistics, experienced Licensed Clinical Social Workers and licensed counselors can expect to earn roughly $40,000 – 60,000 per year, equivalent to $20 - $30 per hour based on full-time employment. Adding an estimated 10 percent of an employee’s salary for employee benefit plans ($4,000 – 6,000) and 6.25 percent of an employee’s salary for payroll taxes ($2,500 – 3,750), the range of direct employment costs varies from $46,500 – 69,750.

Dividing by the standard full-time rate of 2,000 hours of work per year, the effective per hour cost of a licensed professional, $23.25 – 34.88 per hour, can be calculated as follows:

\[
\frac{\text{\$40,000 - 60,000 in base salary} + \text{\$4,000 - 6,000 in benefits (assuming 10 percent of salary) + \$2,500 – 3,750}}{2,000 \text{ hours per year (assuming full-time, 40 hours per week, 50 weeks per year)}} = \text{\$23.25 – 34.88/hr.}
\]

The financial benefits associated with converting to professional service provision are directly linked to the number of clients an organization serves, the socio-economic status of the organization’s clients (meaning whether or not the clients pay for any services), and the mix of reimbursable services it provides. Intangible benefits, including higher quality of care and easier access to professional services for clients are also critical, but will vary widely by organization, organizational mission, and therefore will not be assessed in this report.

This scenario assumes that a full-time Licensed Clinical Social Worker or licensed counselor sees 25 clients per week for 50-minute reimbursable mental health sessions.

The current example assumes that roughly 40 percent (10) of the clients are Medicaid-eligible, 40 percent (10) pay out of pocket, and the remaining 20 percent (5) pay with private insurance or out of pocket.

Based on a mix of child and adult sessions, providers should expect to receive roughly $65 per Medicaid client per 50-minute session. Private provider reimbursement rates vary and can be slightly lower than officially advertised by Medicaid due to billing adjustments, however, providers can expect roughly $55 per reimbursable session from private insurers.\(^\text{10}\)

Self-pay fee estimates are much harder to calculate and depend on the sliding fee schedule an organization establishes. For example, some providers charge from $10 per 50-minute therapy session to over $120 per session, depending on a client’s income. The

\(^{10}\) Across reimbursement methods, providers can bill higher per-minute rates for screening and initial diagnosis sessions than for therapy. For the sake of clarity and simplicity, however, this analysis focuses on the benefits associated with the typical day-to-day 50-minute health sessions on which licensed practitioners spend most of their time.
financial benefit of serving self-pay clients therefore depends heavily on the socio-economic status of the organization’s clients and their particular sliding fee scale. This report will use a $50 average per self-pay client, but any organization considering hiring professional staff can recalculate the numbers below based on its client mix.

Using the above estimates, the total financial benefit of professional services is:

\[
\begin{align*}
\$65 \text{ per Medicaid client} & \times 10 \text{ clients per week} \\
\$55 \text{ per privately insured client} & \times 5 \text{ clients per week} \\
+ \$50 \text{ per self-pay client} & \times 10 \text{ clients per week} \\
\hline
\$1,425 \text{ per week} \\
\end{align*}
\]

\[\$1,425 \text{ per week} \times 50 \text{ weeks per year} = \$71,250 \text{ per year}\]

**Administrative Aspects and Estimated Costs of Reimbursement:**

The paperwork associated with billing for mental health services is subject to much debate and variation depending on an organization’s number of clients and provider experience. Medicaid assumes that paperwork will occur as part of the reimbursable session. The amount of time a provider spends on paperwork (i.e. session notes, treatment plans, and goals) depends largely on the provider’s experience and agency expectations. This analysis assumes that 15 minutes of paperwork will be spent on each 50-minute session.

Based on a per-hour wage or average salary of $23.25-34.88 per hour and an average number of 25 50-minute sessions per week the effective cost range of additional paperwork burden associated with providing professional mental health services may be calculated as follows:

\[
\begin{align*}
15 \text{ minutes of paperwork per session} & \times 25 \text{ sessions per week} = 375 \text{ minutes of paperwork per week} \\
375 \text{ minutes} / 60 \text{ minutes per hour} & = 6.25 \text{ hours per week} \\
6.25 \text{ hours of paperwork per week} & \times 50 \text{ weeks} = 312 \text{ hours of paperwork per year} \\
312 \text{ hours of paperwork per year} & \times \$23.25 - 34.88 \text{ per hour} = \$7,254 - 10,882 / \text{year per full-time provider} \\
\end{align*}
\]

Given that this paperwork cost estimate is heavily dependent on the estimated time spent on paperwork per session, which is highly variable, the following estimated annual paperwork costs are provided to account for alternative circumstances:
10 minutes per session = $4,848 – 7,273 / year per full-time provider
30 minutes per session = $14,542 – 21,818 / year per full-time provider
40 minutes per session = $19,390 – 29,091 / year per full-time provider

From the above paperwork cost data it is apparent that relatively small amounts of daily paperwork can add up to significant burdens annually and can become expensive if paperwork is completed by highly paid, licensed providers. If several professional service staff are spending as much as half of their time on paperwork, related costs can multiply, presenting a financial burden on the organization and adversely affecting services.

If a high percentage of paperwork time is billing-related, it may be more cost effective for an organization to employ clerical staff to complete this paperwork, and/or consider consolidating this function by contracting with an organization to complete paperwork and other administrative tasks, as in the Wesley Shelter example below. However, if paperwork costs are relatively low, or a majority of paperwork time is spent on treatment-related material, a full-time LCSW or licensed counselor should have enough time after completing 25 50-minute sessions per week to also complete record keeping and billing-related paperwork.

A NORTH CAROLINA-BASED CASE IN POINT

Wesley Shelter, located in Wilson, North Carolina, operates a domestic violence program including shelter services, as well as homelessness services, adolescent pregnancy prevention, and other programs. The agency serves nearly 5,000 people a year and has been serving the community since 1983. According to longtime Executive Director Kim Gauss, providing mental health services to Wesley Shelter clients is critical. She notes, “under mental health reform, we had to find a way to provide quality mental health services in a timely manner and in a way that wouldn’t bankrupt the agency.”

Since the Wilson Local Management Entity (LME) became a manager of local mental health services rather than a direct provider, the Wesley Shelter has had difficulty identifying providers who will assess and treat Wesley Shelter’s clients. After investigating and considering options over a number of years, the Wesley Shelter decided to seek the status of a Medicaid-approved provider of mental health services. Their analysis suggested that many of their clients would be Medicaid-eligible, and were presenting with the types of mental health concerns that are covered by Medicaid. The agency hired two full time, salaried therapists and recently established an agreement with a private provider to process paperwork related to Medicaid reimbursement. They hope to begin working under this arrangement by January 2007. The two therapists are currently supported by grant funds. By July 2007, Gauss intends to support them through revenue from Medicaid reimbursements generated through the new billing system.
VI. CONCLUSIONS

Victims of domestic violence and sexual assault have varied and multidimensional needs. Accessing or providing mental health services to persons who have been victimized can carry complicated logistical, practical, and philosophical considerations.

There are three prevailing models for delivering mental health services to clients of domestic violence and sexual assault programs in North Carolina. One model is to work closely with the community to assure that services are accessible, available, and of high quality, and to leave the direct delivery of those services to current mental health providers while establishing a clear mechanism for referral and partnership through formal, (i.e. Memoranda of Understanding), or, informal agreements. This model assumes collaboration and a partnership with the Local Management Entity and involvement in the planning process. A second model is for domestic violence or sexual assault programs to employ or contract with a licensed professional to deliver mental health services who can receive reimbursement from Medicaid and/or other insurance providers. A third model is for the domestic violence or sexual assault service provider to become an approved mental health services provider eligible for reimbursement from Medicaid and other insurers.

To determine the most effective model, service providers should first conduct an analysis of the agency’s current program model for delivering these services, including cost, effectiveness, and sustainability. If the service provider determines that current needs (on behalf of the client, staff or agency) are not being met, they should engage in discussions with their community partners regarding the most effective and viable model for delivering these services and develop a plan. Part of this planning process should involve developing a sustainable funding model by projecting the number of clients the agency sees who will be eligible for various types of services. In the case of Medicaid, the agency should review client income levels and the types of mental health concerns faced by those clients.

In light of the complexity and pace of the changes currently being made to the structure of North Carolina’s mental health system, an immediate plan to become a direct provider of mental health services might be costly and time-consuming; the transformation of the system is on-going and major decisions and changes to the structure of the system are occurring at a steady pace. The inventory of licensed and certified providers is likely to change and has great relevance to how communities plan to deliver their services. The authors of this document recommend that domestic violence and sexual assault service providers become engaged, if they are not already, in the planning efforts of their communities and consider contracting with licensed professionals to deliver the services internally, or develop referral relationships within the community.
Center for Child and Family Policy

The Center for Child and Family Policy brings scholars from many disciplines together with policymakers and practitioners to address problems facing children and families in contemporary society. The Center is a national leader in addressing issues of early childhood adversity, education policy reform, and youth violence and problem behaviors. The Center bridges the gap between research and policy by assisting policymakers in making informed decisions based on sound evidence and research.

The Center supports a variety of research studies in child and family policy and provides comprehensive program evaluation services to local, state and federal policymakers, nonprofit organizations and foundations. Services include strategic consulting for evidence-based program development, evaluating services to document effectiveness, data analysis, establishing monitoring systems, staff training and more. For more information about Program Evaluation Services, contact David Rabiner, 919.613.9304 or drabiner@duke.edu.

The interdisciplinary Center for Child and Family Policy is led by Kenneth A. Dodge, Ph.D. and housed within the Terry Sanford Institute of Public Policy at Duke University in Durham, North Carolina.

Additional Center for Child and Family Policy publications and policy briefs are available at www.childandfamilypolicy.duke.edu.

Recent policy briefs range in topics from:

- Three part series on Student Retention by Claire Xia
- Sorting Out Student Retention by Ryan Kinlaw
- Substance Abuse Prevention by Corrine Wallace
- Funding Strategies for Domestic Violence programs by Kristen Dubay

Any opinions, findings, conclusions or recommendations expressed in this material are those of the author(s) and may not reflect the views of the Center for Child and Family Policy, Terry Sanford Institute of Public Policy or Duke University.

Copyright © 2006