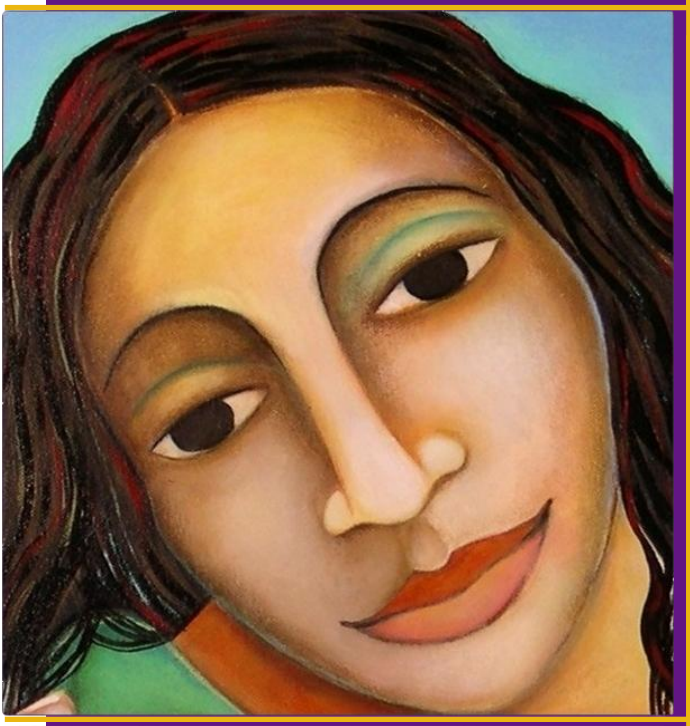

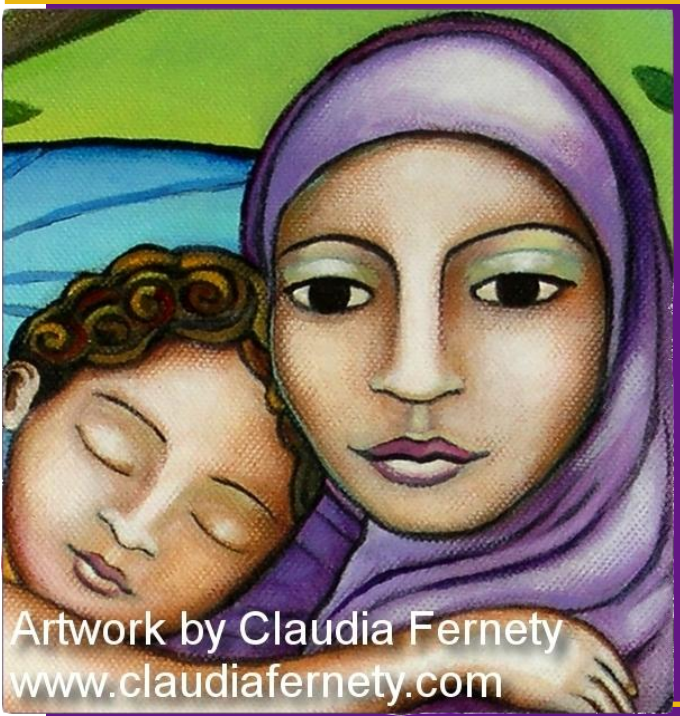

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Family Justice Center Alliance

Local Services, Global Reach

Health Survey Report

Addressing Health Needs of Intimate Partner Violence Survivors in Family Justice Centers

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THE ALLIANCE ACKNOWLEDGES AND APPRECIATES SUPPORT FROM:

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VERIZON FOUNDATION

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OPEN LETTER FROM THE ALLIANCE LEADERSHIP TEAM

Casey Gwinn, President
Gael Strack, CEO

Esteemed Colleagues & Friends,

Anna has no health insurance. She is undocumented, but has three children who are American citizens. She left an abusive relationship four years ago. The criminal justice system responded and her abuser was prosecuted. Now, her children are receiving social and legal services at a local Family Justice Center. Anna and two of her children receive counseling from a psychologist at the Center. But her children have not seen a dentist in over three years. Anna does not have a primary care physician. She went twice to an emergency room for injuries related to domestic violence, but now has no health care for herself or her children. Her psychologist has diagnosed her with depression and she suffers from insomnia. She has high blood pressure but does not take medication. All three of her children have lost baby teeth and each tooth had major decay. Anna cannot read without glasses. She has no vision insurance.

Today, thousands of survivors of domestic violence have unaddressed medical, dental, and vision needs across the United States. Most community-based domestic violence agencies do not have the capacity to meet these needs. Criminal justice interventions, social services, civil legal services, mental health counseling, and other assistance is available in many communities, and multi-agency and multi-disciplinary approaches such as Family Justice Centers are bringing together more accessible services under one roof. **But health related services are not generally included even in the most dynamic multi-agency, multi-disciplinary service approaches.**

The National Family Justice Center Alliance is working with the Verizon Foundation, Blue Shield of California Foundation, and other allied national organizations to address health needs of survivors, particularly in Family Justice Centers or other types of multi-agency, multi-disciplinary service approaches.

The scope of the problem is well documented. In the U.S., 24 percent of adult women and 14 percent of adult men will be physically assaulted by an intimate partner. It is the most common cause of injury for women ages 18 to 44. **And it leads to an increased incidence of chronic disease: Abused women are 70 percent more likely to have heart disease, 80 percent more likely to experience a stroke and 60 percent more likely to develop asthma.** For children growing up in an abusive home, the impact of this trauma affects mortality dramatically according to recent findings of the nationally known ACE Study (Adverse Childhood Experiences). According to Dr. Vincent Fellitti, a child with a score of six (multiple adverse childhood experiences) in the ACE Study has a reduced life expectancy of 19 years compared to a child with no adverse childhood experiences.

It has also been well documented that domestic violence costs $8.3 billion annually: a combination of higher medical costs ($5.8 billion) and lost productivity ($2.5 billion).

Training for health care professionals and thorough screening in the medical settings is critical to raising awareness and identifying health needs of victims. Futures without Violence, the American Medical Association, and other national organizations have helped raise awareness and engage the medical community. As noted recently by Dr. Robert Pearl in Forbes magazine, a growing number of health care professionals and business leaders understand the importance of recognizing and addressing domestic violence. And unless domestic violence can be identified, we can't help victims deal with the abuse or reduce the long-term consequences.

The Affordable Care Act identifies domestic violence screening as a national health priority, alongside smoking cessation, exercise, nutrition, substance abuse reduction and the provision of mental health services. This creates an opportunity for a greater national focus on the health needs of domestic violence survivors.

But beyond the importance of screening and identification, is the critical issue of actually providing needed health services to victims and their children.

In the last decade, research has strongly supported collaborative service delivery models for helping to address the short-term and long-term needs of domestic violence survivors and their children. Family Justice Centers have been identified as a best practice in bringing together many services for victims under one roof and recent research in California has documented the desire of domestic violence survivors to come one place for all their needs. Today, more than 80 Family Justice Centers seek to meet the diverse needs of survivors by bringing government and non-government agencies together in one place rather than expecting victims to go from agency to agency – telling their story over and over again – while trying to get the needed help.

A significant percentage of Centers have identified the need for forensic medical services to document injuries for criminal and civil justice system interventions, but few Centers are addressing the complex health needs of survivors. **This report focuses on the recent research and survey work of the National Family Justice Center Alliance in beginning to identify viable health care service models** for Family Justice Centers and other multi-disciplinary, multi-agency collaborative approaches seeking to meet the short and long-term health care needs of survivors and their children.

Survivors need better access to health care and the integration and coordination of health needs with social service and criminal/civil justice system needs will produce better outcomes for survivors and their children as we seek to reduce violence against women, men, and children in this country.

We are excited to help map this terrain, and grateful for your support and partnership.

Casey Gwinn, J.D.
President
National Family Justice Center Alliance

Gael B. Strack, J.D.
Chief Executive Officer
National Family Justice Center Alliance

EXECUTIVE SUMMARY

PURPOSE

For years, the National Family Justice Center Alliance ("Alliance") has helped develop and sustain over 80 Family Justice Centers (FJCs) offering co-located, multidisciplinary services to victims of domestic violence and their children across the United States. Stemming from the Alliance's role as a national expert and resource center on Strangulation assaults in domestic violence and sexual assault, and in anticipation of the evolving changes in healthcare, we have long- recognized the health needs and significant health consequences that victims of violence experience. To address this area of need, the Alliance partnered with the **Blue Shield of California Foundation and the Verizon Foundation** to launch a Health Initiative with the goal of developing and testing viable models to integrate health services into the scope of care that Family Justice Centers provide.

The Alliance conducted a national survey among victims in FJCs to identify the major health needs and barriers to care they face. Focus groups and organizational audits were done to contribute to the findings and assess the capacity of FJCs to integrate health services with criminal justice, civil legal, social, mental health, and other services currently offered in Centers. Following a review of the findings, we offer recommendations for FJCs and other mulit-disciplinary domestic violence (DV) organizations across the United States.

OVERVIEW: WHAT WE KNOW

The health effects of domestic violence are vast and long lasting, affecting nearly every aspect of health. Beyond direct injuries from physical abuse, victims suffer disproportionately from indirect effects of long-term abuse:

- Women who experience abuse are 3 times more likely to have reproductive health complications than non-victims (Campbell, 2002),
- 48% of women who are abused will also experience depression (Hernandez, 2012),
- Victims are more likely to use Emergency Rooms for regular health care (Reisenfhofer & Seibold, 2012)
- Victims are significantly more likely to have a chronic illness than non-victims (Verizon Foundation, 2013).
- The economic impact of violence is estimated at $5.8 - $8.3 billion each year; the vast majority attributed to healthcare costs and lost productivity (CDC, 2013).

The research to-date has largely been conducted in clinical, medical settings, and current interventions mainly target healthcare providers to screen and provide referrals for victims. The Patient Protection and Affordable Care Act of 2010 has expanded this practice by including provisions guaranteeing women's health services. However, while research shows that providers believe screening for DV is important, we have not seen systematic changes or improved outcomes from screening interventions (Hegarty et al., 2013).

RESULTS: WHAT WE FOUND

The Alliance conducted a national survey of survivors' health needs and barriers to care during one week in October 2013. The survey addressed physical, sexual, mental, dental, vision, and

behavioral health history. Fourteen Family Justice Centers participated in the national health survey.

The major findings include:

- **Respondents were largely un/under-insured**: 44% have no insurance and of those with insurance 65% have public insurance such as Medicaid or Medicare.
- **Almost 70% reported at least one health need**, but only 49% reported having a primary care provider.
- **Half went to an Emergency Room**, while only 30% saw their primary care provider in 2013.
- **Respondents reported more mental health needs** (an average of 4 concerns) than physical or sexual health needs.
- **Dental and vision services were the most requested** health services: 40% and 43%, respectively, would like to have services available in FJCs.
- **The primary barriers to care were Insurance and Cost**; these were most prevalent for dental and vision care.
- **While most reported they would like more health services** available at FJCs, the primary needs were civil-legal, therapeutic, and social services, suggesting that mental health is important to victims, but addressing broader health needs may need to be addressed by building awareness and integrating services and support into advocacy.

Qualitative data used in the national survey was collected via focus groups, interviews and document review. This data provided important insight into the process of integrating health into FJC services. Key themes included:

- **Staging health assessments and the methods of support** are important: Health services should be integrated into the whole practice of advocacy and support for victims.
- **Training is needed for professionals** in identifying potential or underlying health issues.
- **Issues of literacy should be considered** when assessing health needs.
- **Tracking health needs** through standardized questions at intake may help partner communication in addressing health needs.

RECOMMENDATIONS

Given the health needs of survivors and the capacity of FJCs, expanding forensic medical units and/or Sexual Assault Response Teams to provide broader health services and linking victims into long-term advocacy appear the most promising practices. Building partnerships with the local health sector is a vital first step. As the Alliance moves ahead testing operational models, we recommend preliminary action-steps to all FJCs:

- **Engage the health sector** as partners in Centers to develop program models
- **Add key health questions into the FJC intake process** and partner agency assessments.
- **Train staff and volunteers** on the non-acute health needs of survivors.
- **Establish protocols for following-up on health needs**, methods for support, and referring between partner agencies to address emerging health needs.

INTRODUCTION

About the Alliance

Casey Gwinn and Gael Strack, the founders of the San Diego Family Justice Center, launched the Family Justice Center Alliance after the development of the President's Family Justice Center Initiative in 2004. At the request of the U.S. Department of Justice, the San Diego Family Justice Center team was asked to develop a technical assistance program to support new and developing Centers across the country. Since its inception in 2004, the Alliance has been expanding and broadening its services in response to the increasing demand for technical assistance (consulting, training, planning, and support services) from existing and developing Family Justice Centers in the United States and around the world.

Today, the Alliance serves as the clearinghouse, research center, and national membership organization for all Family Justice Centers and similar multi-agency, multi-disciplinary service delivery models serving victims of domestic violence, sexual assault, elder abuse, and other forms of abuse and oppression. The Alliance also develops innovative, promising practice models to meet the needs of victims and their children in multi-agency service approaches including, Camp HOPE California, the Center for Solo Practitioners, and a host of other projects.

The Alliance also operates the Training Institute for Strangulation Prevention (TISP), the most comprehensive training program in the country for professionals working with survivors of near-fatal strangulation assaults. The TISP provides online and curriculum-based training for doctors, nurses, police officers, prosecutors, advocates, mental health professionals, and others working to address near and non-fatal strangulation assaults in the U.S. and around the world.

Our Vision

Our vision is to create a future where: ALL the needs of victims are met; Children are protected; Abusers are held accountable; Violence fades; Economic justice increases; Families heal and thrive; Hope is realized; and we ALL work together.

Our Mission

Our mission is to create a network of national and international Family Justice Centers and similar co-located service models with close working relationships, innovative practices, shared training and technical assistance, collaborative learning processes, coordinated funding assistance, and transformational leadership.

The Alliance serves as the technical assistance and training provider for the United States Department of Justice for federally funded Family Justice Centers. The Alliance also works with Centers outside the federal initiative in the U.S. and abroad. There are currently more than 80 operational Centers in the United States with more than 20 international Centers (Canada, Mexico, England, Jordan, and Sweden). There are over 100 Centers currently developing in the United States, Europe, the Middle East, Africa, and Central America. The Alliance is partnered with Movisie (Movisie.nl) in The Netherlands to develop six pilot Centers under a European Union Family Justice Center Initiative. The Alliance is also partnered with the Mexican government and USAID to help open more than twenty Women's Justice Centers in Mexico – the largest international Family Justice Center initiative.

Guiding Principles

•Increase safety, promote healing, and foster empowerment through services for victims and their children

•Provide victim-centered services that promote victim autonomy

•Commitment to the utilization of culturally competent services approaches that are measurable and behavior based

•Engage all communities through outreach and community education

•Shape services to clients by asking them what they need

•Evaluate and adjust services by including survivor input

•Maintain close working relationships among all collaborators/agencies (law enforcement, prosecution, community- based domestic violence programs, civil legal service providers, health services programs, and other social services)

•Offer survivors a place to belong even after crisis intervention services are no longer necessary

•Integrate primary, secondary and tertiary prevention approaches into all initiatives, programs, and projects

•Develop a Family Justice Center Community that values, affirms, recognizes and supports staff, volunteers, and clients

HEALTH INITIATIVE OVERVIEW

PURPOSE

The Alliance has worked in partnership with the Verizon Foundation and Verizon Wireless for more than ten years to first develop the San Diego Family Justice Center and then develop the Family Justice Center Institute to support developing and operating Family Justice Centers around the United States through technology initiatives and other promising practices. The Verizon Foundation has continued its partnership with the Alliance by supporting the development of this Health Initiative.

The purpose of our Health Initiative is to assess the health needs of survivors accessing FJC services, and use technical assistance to develop viable models for effective on- and off-site health services.

The work of the Alliance's Health Initiative falls into three phases:

1) **Study and Planning**: conduct a health needs assessment and develop pilot site plans for health service expansion.
2) **Implementation and Evaluation**: In partnership with an operational FJC, document promising practices, implement the planned pilot project, and develop resources for all FJCs.
3) **Training and Technical Assistance**: Develop resources, trainings, technical assistance and other learning exchange projects for the dissemination of the project successes.

OBJECTIVES

This report provides an overview of the Study and Planning Phase, including recommendations.
The objectives of this Phase were to:

1. Assess survivors' health needs/concerns.
2. Assess survivors' access and barriers to health services.
3. Identify promising medical/health models for FJCs.

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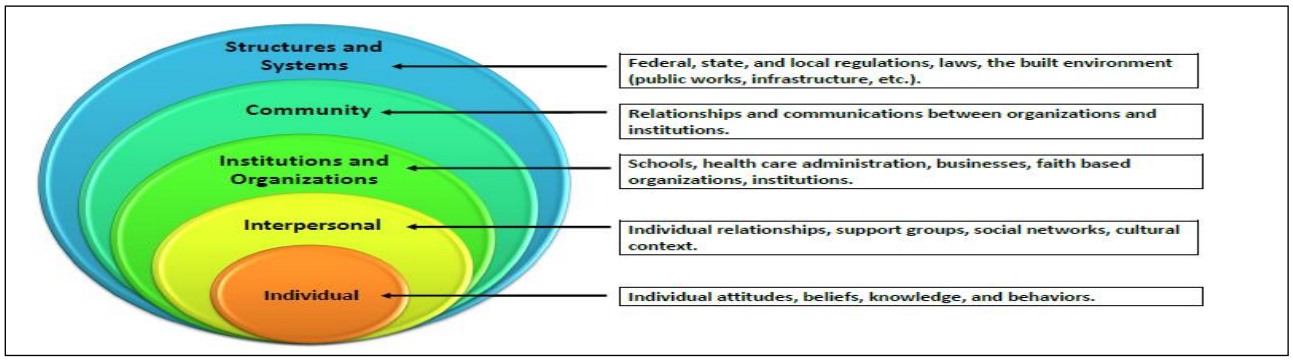
PUBLIC HEALTH APPROACH

Domestic violence or intimate partner violence (IPV), has been recognized as a public health issue since 1965 and has been a national priority since 1990 (Healthy People, 2010). A public health approach often relies on an "ecological" framework for understanding the different factors contributing to a health problem.

The Social Ecological Model: Depicts the multiple levels of influence on health (CDC, 2013).



As a public health concern, victims of domestic violence are more likely to experience multiple secondary health effects such as depression, anxiety, chronic pain, diabetes, engage in health risk behaviors (e.g. smoking), and reproductive/sexual health problems (Campbell, 2002; Dahlberg & Mercy, 2009). Given that domestic violence continues to occur in isolation, survivors' health is determined by their experience of violence, and is largely left unmet.

Consequences of IPV in Ecological Context: Using the CDC's data on IPV (CDC, 2013)

1 in 4 Women; 1 in 7 Men: Individual health effects: Direct injury, indirect physical, reproductive, and psychological health effects via chronic stress, negative health behaviors.
Children: Injury or vicarious trauma from witnessing DV.
Work Productivity: Victims of "severe IPV" lose nearly 8 million days of paid work each year (=32,000 jobs).
Isolation: Victims are cut-off from their social networks, and are restricted from accessing services.
Unemployment & Homelessness: Women who experience sever abuse are more likely to have been unemployed and on public assistance.

SCOPE OF HEALTH NEED

GLOBAL TO LOCAL: COSTS OF IPV

The global prevalence of intimate partner violence (IPV) and its effects, including high levels of femicide, persist despite decades of effort (Stockl et al., 2013; Hegarty et al., 2013). In the United States, IPV rates continue at alarming levels; one in four women will experience partner abuse in her lifetime; one in seven men (CDC, 2013). Beyond the devastating impacts of violence to individuals, families, and communities IPV costs $5.8 billion annually (Jones et al., 2004). **A recent update estimates economic costs from IPV at $8.3 billion** (CDC, 2013). This is not surprising given that a single domestic violence homicide in San Diego County cost up to $2.5 million in 1994 (Gwinn & Strack, 2006).

NATIONALLY:
Intimate Partner Violence costs $5.8 billion annually, $4.1 billion related to healthcare costs.

LOCALLY:
A single domestic violence homicide cost up to $2,555,793 in San Diego County in 1994.

HEALTH CONSEQUENCES OF IPV

Jacquelyn Campbell's original research linking poor health with IPV initiated a move to educate the health sector on IPV and provide routine domestic violence screenings to encourage disclosure and service provision (Campbell, 2002). Unfortunately, routine screening has not been universally implemented, leading to inconsistent outcomes (Hegarty et al., 2013). And yet the health effects of IPV are vast – both acute and long-lasting, affecting nearly every aspect of health.

Research conducted in health care settings has revealed direct, physical health consequences that include physical injuries, non-fatal strangulation, head trauma, chronic pain, and poor pregnancy outcomes (e.g. low birth weight) (Campbell et al., 2003; Plichta, 2004, WHO, 2013).

Acute injuries are the most recognizable, but chronic injuries from repeated "non-severe" abuse, chronic stress, or other immune suppressants can produce indirect and long-term health effects (Wuest et al., 2010). The Verizon Foundation recently conducted a survey using a representative sample of women and found that **women who have experienced domestic violence are significantly more likely to have a chronic illness (88% vs. 70% in all women)** (Verizon Foundation, 2013).

Common Physical Consequences:

Bruising
Broken bones
Traumatic Brain Injury
Back or Pelvic pain
Headaches

Chronic Conditions:

Asthma
Bladder/kidney infections
Cardiovascular disease
High Blood Pressure
Irritable Bowel Syndrome
Chronic Pain
Central Nervous System Disorders
Fibromyalgia
Migraines/headaches
Diabetes

Survivors are **3 TIMES** more likely to have **gynecological or sexual health** problems than non-victims.

Mental Health Consequences:

Anxiety
Depression
Post-Traumatic Stress Disorder
Antisocial behaviors
Suicide ideation
Low self-esteem
Fear
Emotional detachment
Sleep disorders
Flashbacks

Health-Risk Behaviors:

Unprotected sex
Trading sex for food or other resources
Smoking
Drinking alcohol
Drug use
Unhealthy eating
Overuse of health services

Survivors are three times as likely to suffer from gynecological and sexual health problems as non-victims (Campbell, 2002). This is often due to sexual assault or coercion that accompanies other forms of IPV. Research shows that abuse often increases in severity and frequency during pregnancy.

Indirect physical effects include central nervous system symptoms (headaches, fainting, back pain, seizures), and gastrointestinal conditions (e.g. irritable bowel syndrome, appetite changes, eating disorders). ***These indirect effects are widely attributed to chronic stress*** of managing an abusive environment, beyond any direct physical injury or trauma (Reisenhofer & Seibold, 2012).

IPV survivors generally ***self-report lower overall health than average*** (Plichta, 2004; Mathew et al., 2013), and may engage in more health-risk behaviors (e.g. poor diet, smoking, substance abuse) (Campbell, 2002).

In a study on women entering a domestic violence shelter, almost half the residents reported needing to address health issues for themselves (Lyon, Lane & Menard, 2008). However, from a list of 38 needs, health ranked 19th. ***The Verizon Foundation (2013) survey also found that neither victims nor their health providers "are making the connection between chronic health conditions and domestic violence".***

48% of women who experience DV also experience ***depression***.
-Hernandez, Marshall & Mineo, 2013

Less data is available on the dental health needs of survivors, yet both researchers and practitioners stress the need for more research. One study reported ***that only 13% of women in shelter were asked about dental needs, while 70% reported a dental need (Abel et al., 2012).*** Another needs assessment found that survivors had not seen a dentist in years and presented with needs for dentures, extractions, restorations, dental prophylaxis, and dental education (Abel et al., 2012).

Survivors report **LOWER OVERALL HEALTH** than the average population.

Indirect health effects of abuse are associated with **CHRONIC STRESS.**

Health ranked **19TH OUT OF 38 PRIMARY NEEDS** for women in shelters.

LEARNING FROM STRANGULATION

The Alliance leads the most robust program in the nation for improving the identification, assessment, documentation, prosecution, and advocacy support around near- and non-fatal strangulation assaults. Through our Training Institute on Strangulation Prevention (TISP), we have trained thousands of professionals and advocates from multidisciplinary fields. It was through this work that we noted the similarities in strangulation to the broader health needs of survivors. Some of the main messages we emphasize in our trainings on strangulation (in bold below) hold true for emerging evidence on health and IPV (in italics):

Survivors do not realize the possible health impacts from non-fatal strangulation.

- *Only 54% of women recognize the connection between chronic health conditions and domestic violence (Verizon Foundation, 2013)*
- *Less than 1 in 4 attributed their physical health to abuse (Alliance Survey, 2013).*
- *From a list of 38 needs, health ranked 19th despite most women citing a need for healthcare (Lyon, Lane & Menard, 2008).*

Strangulation often leaves no visible injury

- *"Women who are abused are frequently treated within health-care systems, however, they generally do not present with obvious trauma, even in accident and emergency departments (Campbell, 2002, p.1331)."*

Children are present in more than 50% of strangulation assaults

- *Witnessing domestic violence during childhood has deep impacts on development by creating a focus on survival, interrupting learning, and producing chronic health and behavioral disorders (Chamberlain, 2013)*

Providers do not ask about strangulation

- *In a qualitative study in Australia, women reported receiving good physical care, but "acknowledgement of IPV and psychosocial care was consistently overlooked" (Reisenhofer & Seibold, 2012, p.3357).*
- *3% of dentists ask questions about domestic violence (Verizon Foundation, 2013).*

It is, in part, because of these connections that we are committed to addressing the broader health consequences and basic health needs that survivors disproportionately face in IPV.

THE TRAINING INSTITUTE ON STRANGULATION PREVENTION, A PROGRAM OF THE NFJCA

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Help Seeking and the Role of Health Care Settings

While help seeking among survivors of IPV is known to increase as abuse severity increases (Duterte et al., 2008), survivor health needs remain unmet or underserved. ***9 to 22% of abused women will seek medical treatment at some point*** (Duterte et al., 2008). Women experiencing severe physical or sexual abuse are more likely to seek formal help, and represent a significant portion of the numbers seeking care in emergency departments (Reisenhofer & Seibold, 2012; Kramer, Lorenzo & Mueller, 2004).

Research overwhelmingly points to the role of partnerships, coordination, multidisciplinary teams, inter-organizational collaboration, and co-located models of victim service as the best-positioned efforts to continually offer innovative services and better address health needs of survivors (McGarry, Ney, 2006; Knoben and Oerlemans, 2006; Gewirtz, 2010; Munger, 2010; Gwinn, Strack, 2010; Uddin and Hossain, 2011b; Petrucci, 2013).

HIGHLIGHTS: MEDICAL HELP-SEEKING

- **9 to 22%** of abused women will seek medical treatment at some point.
- "Women who are abused are frequently treated within health-care systems, however, they ***generally do not present with obvious trauma,*** even in accident and emergency departments (Campbell, 2002)."
- ***Increased severity of abuse*** is associated with higher rates of help-seeking from formal services, including medical care.
- DV victims make up a significant proportion of people using Emergency Rooms.
- ***Health care costs of abused women are over twice*** that of never-abused women (or $4,500 more).
- Multidisciplinary and co-located organizations are best-equipped to systematically address overall health needs of survivors.

Need for Health Integration into IPV Response

Current research on the intersection of health and intimate partner violence (IPV) consistently points to multidisciplinary, co-located organizational models as the best-equipped settings to tackle the challenge of integrating health services into the broader IPV system of support (Rhodes et al., 2013; Browne et al., 2012; WHO, 2013, Feder, Wathen & MacMillan, 2013).

The following chart provides a brief review of current interventions addressing the health needs of survivors.

Brief Review of Interventions: DV and Health

Author	Findings
Individual Level (Behavioral) Interventions	
Mathew, A., Smith, S., Marsh, B., & Houry, D., 2013	Women who perform self-breast exams and get sexual health screenings (STI/SHIV) are less likely to experience IPV (Mathew et al., 2013).
Rhodes et al., 2012	When asked, IPV victims are 2 times as likely to disclose to providers.
Jack et al., 2012	Victim readiness to change is important in providing health and social service support.
Interpersonal Level Interventions: Health Providers & Advocates	
Rhodes et al., 2012	Providers already believe screening is important, but face multiple barriers to incorporating into routine care (Rhodes et al., 2013). DV screening by "IPV specialists" (navigators) improved victim satisfaction with healthcare. Screening not easily integrated into health practice.
Jack et al.,	Health outreach (e.g. home visitors) improved nurse-survivor relationships and increased disclosure of abuse.
Organizational Level Interventions (Programs)	
Jack et al., 2012	Nurse home-visitation programs (e.g. Nurse Family Partnership) are well-equipped to screen for DV and provide needed support. Training on DV assessment and safety planning is needed. Organizations need to provide supervision, policies, safety, and resource knowledge to nurses/home visitors.
Klevens et al., 2011	Computer/electronic DV screenings in clinical settings achieve increased rates of disclosure. Providers need to follow-up orally to connect to resources. Tracking/flagging DV cases may improve health/DV coordination/ response.
Community Level Interventions	
Abel et al., 2012	Using a "collaborative clinic" model and resident rotation, 58 survivors and 18 of their children received dental care in one month.

	Community and program "champions" to market health services are valuable.
Ford-Gilboe et al., 2011	Primary Care interventions for abused women need to prioritize safety and basic needs. Survivors' stories and community stakeholders need to be included in primary care programs and planning.
System/Policy Level Interventions	
Rhodes et al., 2013	Advocates and DV professionals should be included as a part of the Affordable Care Act's "medical home" model.
Lemak et al., 2004	Insurance and/or medical options for immigrant victims are needed. Systematic training of advocates to enroll victims in new health insurance plans is needed.

GAPS

Overall, more victims are likely to seek medical attention than formal social services for domestic violence. However, this population is less likely to disclose abuse and DV screening and referral has not been systematically implemented.

While we understand the breadth of health consequences facing IPV survivors over time, ***less research has documented health needs or priorities from a victim perspective upon entering a social service organization*** (Reisenhofer & Seibold, 2012). As noted earlier, victims of IPV appear more likely to focus on social service and legal needs during the crisis intervention process than on health needs. Once victims have received crisis intervention advocacy, social services, and legal assistance, they may be more likely to desire to address health needs. Family Justice Centers and multi-disciplinary community-based DV agencies with an array of services may better provide for healthcare services given their longer term and ongoing relationships with survivors after crisis intervention. Centers and multi-disciplinary community-based agencies may also have the capacity to foster systems change by partnering with the health sector for long-term change initiatives. Crisis intervention programs with only short-term 30-90 day services may not maintain a relationship with survivors long enough to address long-term health needs.

The following research was conducted to 1) survey the health needs of survivors accessing FJCs, and 2) identify medical models that can best serve these needs.

DATA COLLECTION METHOD

We utilized a mixed-methods approach to capture both qualitative and quantitative data on health needs and the multiple approaches of current and potential practices.

FOCUS GROUP: MEDICAL PROFESSIONALS

The purpose of this focus group was to bring together medical and DV professionals to discuss the different system operations, identify potential (ideal) partnership models in contrast to what is feasible, and to strategize next steps in program development.

SURVEY: SURVIVORS ACCESSING FJC SERVICES

Self-reports – self-administered surveys – were distributed nationally in order to capture a broader scope of health needs, and to ensure confidentiality among participants.

KEY INFORMANT INTERVIEWS: ADVOCATES AND PROGRAMMATIC STAFF AT FJCS

Following the survey, qualitative interviews were conducted with program level staff of FJCs to explore how advocates, counselors, and caseworkers assess and support health needs, identify training opportunities, and consider barriers and facilitators to future program implementation.

DOCUMENT REVIEW

Notes from ongoing technical assistance, survey feedback, and intake/assessment document reviews contributed to this data for the purposed of triangulation.

FOCUS GROUP: MEDICAL PROFESSIONALS

To best understand the capacity FJCs have to integrate health services, the Alliance convened a focus group of medical professionals and DV experts to examine the possible medical models in FJCs. This focus group was held during the summer of 2013 and consisted of 7 medical professionals, including hospital social workers, nurses, doctors, therapists, and forensic examiners, 4 domestic violence experts, 1 facilitator and 1 note taker. The major findings from this Medical Focus Group included:

THE DREAM:

To develop ***on-site FJC health services utilizing*** medical staff from the local health sector to connect survivors to long-term care.

CURRENT PRACTICE:

Many FJCs have forensic medical units for the purpose of collecting evidence should the survivor engage in prosecution or the criminal-justice system; these units have the capacity to conduct broader health

Focus Group Findings:

- **On-site health clinics** are viable.
- FJCs with **forensic medical units** have the capacity to serve broader health needs.
- Each FJC needs to **tailor health services** to their clientele.
- **Partnership building** is the first and most important step.

assessments, but training and engaging stakeholders from the health sector is needed. Hospitals and clinical settings are often overburdened with screening and providing social services referrals for multiple needs is not prioritized; The impending Health Reform roll-out, complexity of healthcare system needs (services, insurance, health information technology), and beliefs about the scope of healthcare services are important barriers to address in partnerships or co-located services models.

DEFINING THE ISSUE:

The potential scope of health needs among FJC clients is vast. These needs should be assessed generally for each community, then tailored to develop feasible and important programs.

PARTNERSHIP BUILDING:

The domestic violence advocacy system and healthcare sector, including public health, need to get to know each other better to address 1) issues of mandatory medical reporting (health) and confidentiality/information-sharing (FJCs), 2) different systems of assessment, monitoring and funding, 3) understand the dynamics of the advocacy system (health) and the changing healthcare terrain (FJCs).

> I met with a woman; she had one child and had another baby a few weeks ago. In our meetings she was sleepy, had trouble focusing, and couldn't remember things. At first, I couldn't peg what was going on. I knew she had struggled with substance abuse issues in the past, but I didn't know that that she had a history of Post-partum depression. Because I was visiting in the home, I eventually found out some health history from her family members. Everyone was afraid to talk about her health issues for fear of child custody…I would love a "go-to" nurse or health services at the FJC to help with these cases.
>
> –Home Visitation Advocate

SURVIVOR HEALTH SURVEY

SURVEY DEVELOPMENT

A survey of health needs and barriers to care was developed in consultation with medical professionals, using existing validated health measures, literature review, and pilot tested by both former (Alliance's VOICES Committee members) and current clients at the San Diego FJC. The survey was available in Spanish and English, completely confidential, and was distributed via pre-identified "coordinators" from each participating FJC. The coordinators used convenience sampling to distribute the survey.

We recruited FJCs to participate via conference calls, emails, and individual calls. The participating Centers included Family Justice Centers in rural, suburban, and urban communities across the United States. The survey was conducted during the first week in October 2013. The survey covered a complete health history (See Appendix for full survey).

SURVEY COMPONENTS

- **Basic non-identifying demographics**
- **Insurance coverage**
- **Physical Health History**
- **Sexual Health History**
- **Mental Health History**
- **Dental/Vision Health History**
- **Behavioral Health**
- **Preventive Health**
- **Barriers to healthcare**
- **Desired Health Services**

PARTICIPATING FAMILY JUSTICE CENTERS
Westchester County Office for Women, New York
Crystal Judson Family Justice Center, Washington
Yolo FJC, California
The Gateway Center for Domestic Violence, Oregon
One Safe Place, Texas
FJC of Ouachita Parish, Louisiana
Solano FJC, California
Nampa FJC, Idaho
Peoria County FJC, Illinois
San Diego FJC, California
Montgomery County FJC, Maryland
Family Safety Center, Oklahoma
Orange County FJC, California
Essex FJC, New Jersey

Results

Survey results were entered into a secure database created and managed by the Public Health Program Associate of the Alliance. Aggregated results were extracted into Microsoft Excel, where basic descriptive statistics were completed.

Demographics

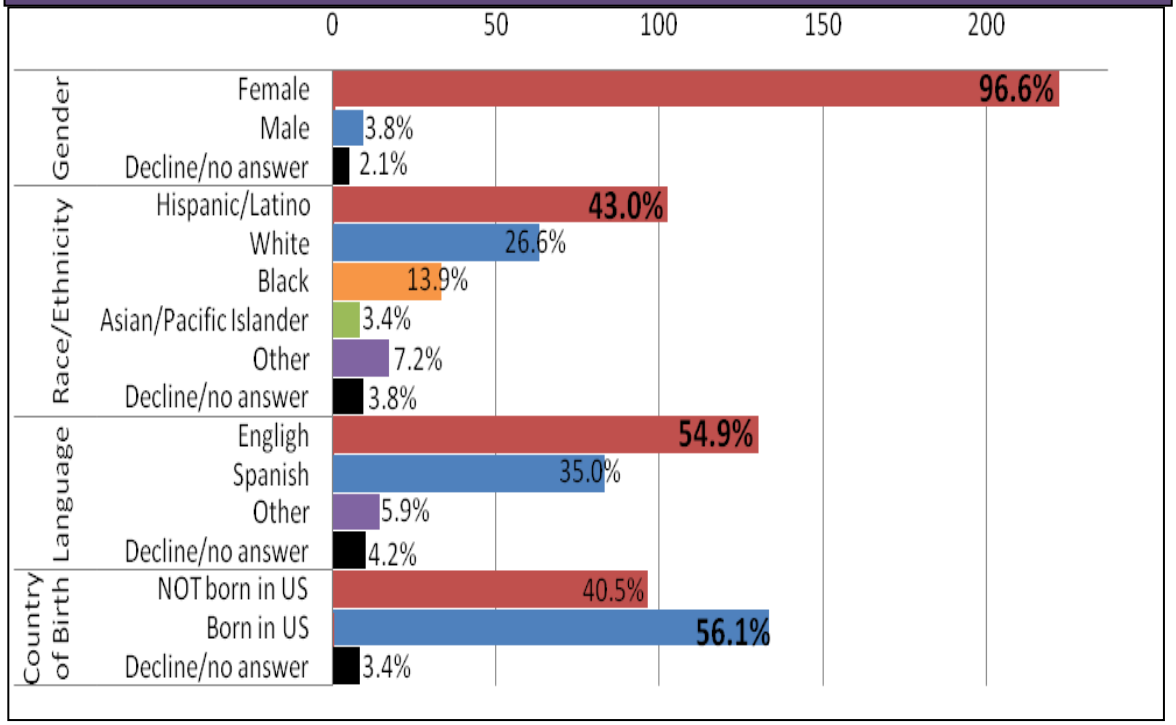
Respondents were primarily female, Latina, and just over half reported English as their primary language. 56% were born in the US (40% were not). Over half of the respondents use the FJC for occasional or ongoing services

Total Participants = 237

From 14 Family Justice Centers

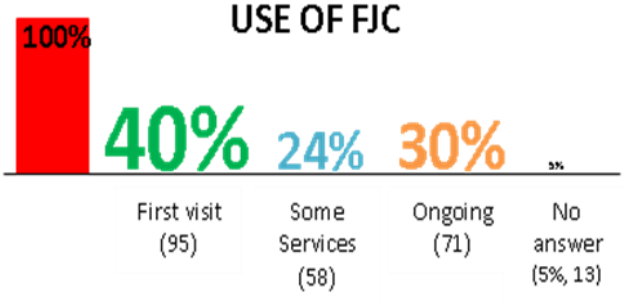
Across 11 states

Figure 1. Demographics: Gender, Race/ethnicity, Primary Language, Birth Origen



On average, FJC clients have 2 children living at home (x=1.91).

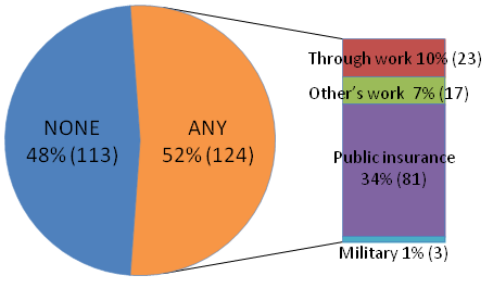
Figure 2. Participant Use of Family Justice Center



Insurance

Only 52% of respondents report having some type of insurance coverage, with the majority reporting public insurance (e.g. Medicaid). 44% report no insurance coverage.

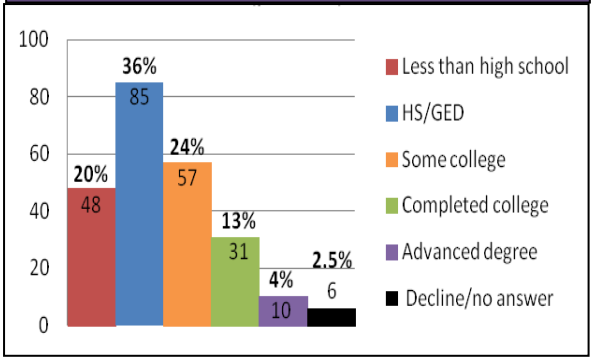
Figure 3. Do you have insurance?



Education

Almost 2/3 of respondents have received a high school diploma, GED, or less. Most respondents have children (87%) with an average of 2 living at home.

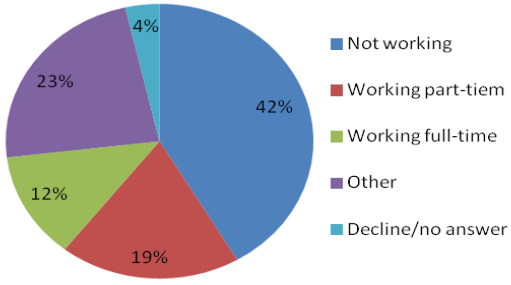
Figure 4. Level of Education



Employment

The majority of participants do not work or are unemployed. One-third have part- or full-time employment, which may explain the higher rates of public insurance over employer or private insurance.

Figure 5. Current Employment Status



PHYSICAL & SEXUAL HEALTH

HEADACHES (38%), FATIGUE (24%), CONSTANT PAIN (16%) WERE THE *MOST COMMON* HEALTH NEEDS.

MENTAL HEALTH

85% of RESPONDENTS REPORTED AT LEAST ONE MENTAL HEALTH NEED.

DENTAL HEALTH

2 in 3 RESPONDENTS REPORTED BASIC DENTAL NEEDS.
Only 30% had seen a dentist in the last 12 months.

VISION HEALTH

Over HALF OF RESPONDENTS REPORT BASIC VISION NEEDS.
Only 1 in 4 have seen an eye doctor in the last 12 months.

Overall, respondents describe their physical and mental health as LESS THAN "GOOD".
(2.5 on a 4 point scale)

Physical & Sexual Health

On a scale of 1 to 4 (1=Poor, 4=Excellent), on average respondents rated their physical health between "fair" and "good" (x=2.55, sd=0.85***). About half reported having a primary care provider, but only 30% had seen a physician in the last year (in 2013).*** Two-thirds reported at least one physical health concern, and on average reported at least 2 concerns.

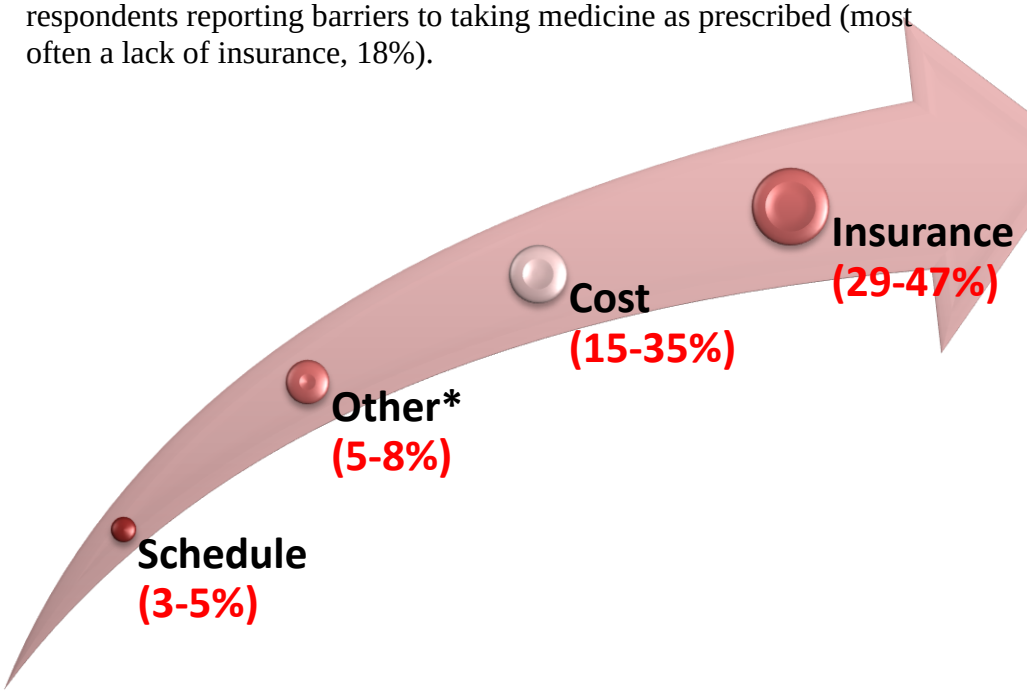
The physical health issues most commonly identified were headaches (38%), Fatigue (24%), Constant pain (16%), high blood pressure (15%), or "Other" (14%), which most often included anemia, cholesterol, or stress/mental health concerns.

Almost **70%** reported at least one physical health need, but only **49%** had a primary care provider and **30%** saw a doctor in 2013.

HALF had gone to the Emergency Room in the past year.

Fewer reported sexual health issues (32%), the most common being urinary or vaginal infections (14%, 9%), or sexually transmitted infections (STI) (10%). ***Less than a quarter attributed their physical health concerns to abuse.***

About half of respondents reported at least one barrier to treatment, no or limited insurance coverage being the most commonly reported reason (30%). Just under one half of the respondents reported going to the ER in the last year. Almost 60% had been prescribed medication, with 1 in 3 respondents reporting barriers to taking medicine as prescribed (most often a lack of insurance, 18%).



Barriers

The majority of respondents reported at least one barrier to care for ALL types of health. More barriers exist for dental and vision (83% and 77%, respectively) than physical or mental health needs.

Respondents cited **no/under insurance as the main barrier to care**, particularly for vision and dental needs. 47% cited insurance as a barrier for dental and vision care vs. 29% for physical and mental health.

****includes spouse/partner restricting access to care.***

While most have more than one mental health concern,

only 1 in 3

have seen a mental health professional.

On average, respondents report **at *least 4 mental health concerns***.

Respondents reported the most barriers to care for **Dental and Vision services**:
no insurance (48%) and **cost (35%)** are the main reasons for not receiving care.

Mental Health

Similar to physical health, respondents rated their mental health between "fair" and "good", on average (x=2.59, sd=0.87). However, more respondents reported having mental health concerns (85% reported at least one) than physical health concerns; ***on average reporting at least 4 mental health concerns***.

The most commonly reported mental health concerns were anxiety (61%), insomnia or sleep problems (50%), low self-esteem (50%), changes in appetite (39%), and panic attacks (37%).

In contrast to physical/sexual health, many more respondents attributed their mental health to the abuse they experience (54% v. 21%). ***Only 1/3 had seen a mental health professional in the last year, with 70% reporting at least one barrier to care*** (most often no/under insurance, 27%).

Dental & Vision Health

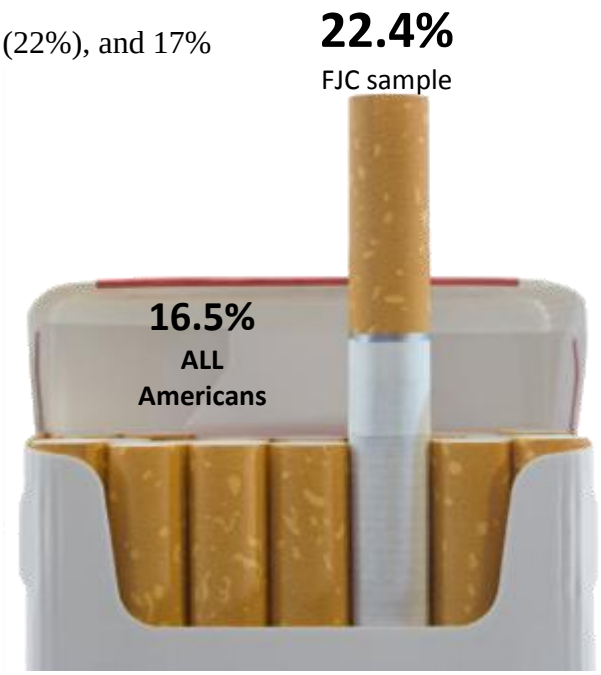
Dental and vision health concerns emerged as a large unmet need of respondents. Over half of respondents reported at least one dental health concern, most commonly cavities (38%), gum sensitivity (22%), tooth pain (22%), and broken or missing teeth (20%).

Less than one-third had visited a dentist in the past year, with most citing insurance (48%) and cost (35%) as the primary barriers. Similarly, a ***large majority of respondents reported basic vision problems, but three-quarters reported barriers to care.***

Behavioral Health

Most respondents reported never or rarely drinking (less than one day per week and less than one drink per drinking day, on average). Similarly, most reported never using recreational drugs. There was large non-response to these questions, which may suggest stigmatization around substance use, particularly when coupled with victimization.

On the other hand, many more reported ever smoking (22%), and 17% smoked to some extent daily. ***This is greater than the national average, where 16.5% of adult women report smoking (CDC, 2011).*** Respondents engaged in physical activity an average of 2 days per week, and reported drinking soda 1-2 times per week. One third reported having difficulty with daily tasks, and of those respondents only 14% reported having someone who helps them.



FJC SERVICES

60% of respondents reported having received any preventive health service, such as blood pressure or cholesterol screenings.

The most commonly reported preventive health services were women's sexual health screenings (pap smears, 37%), regular dental screenings (25%), blood pressure and cholesterol screenings (22%, 16%), and receiving the flu vaccine (16%).

If health services were offered at FJCs, respondents most often requested vision and dental services (40%, 43%), followed by mental health services (34%) and women's health services (30%). 20% requested assistance enrolling in health insurance programs.

What are the **TWO MOST IMPORTANT** FJC services for you?

CIVIL-LEGAL & THERAPEUTIC SERVICES = 20.7%

SOCIAL & THERAPEUTIC SERVICES = 17.7%

SOCIAL & CIVIL-LEGAL SERVICES = 14.8%

CHILD & THERAPEUTIC SERVICE = 12.7%

HEALTH & THERAPEAUTIC SERVICES = 11.4%

LIMITATIONS

There are important limitations to this data. First, the data and sample size (N=237) may not be representative or generalizable to the whole FJC population. Our research also focused on survivors accessing formal services at FJCs, therefore does not represent the range of needs of IPV victims who have not yet sought services or currently access other forms of assistance. Similarly non-response on certain survey items was high, ranging from 5 to 40%. This could be due to the sensitive nature of health history questions, the variability of when and where the surveys were distributed at each site (i.e. a busy intake or reception area), or competing demands of survivors to give full attention to the survey. Finally, FJC clients are not currently accessing health services at FJCs so deeming them an important part of FJC services is unlikely in the absence of the availability of such services at the present time.

Despite these limitations, our findings are consistent with the broader literature on the health needs and multiple barriers to care that survivors face.

Few studies have assessed the health needs of survivors in non-clinical, non-medical settings. And while more survivors may interact with the health system than formal services, there are longstanding gaps in the implementation of DV screening and referral; the advocacy system, particularly FJCs with multi-disciplinary teams may best pave the road in integrating health into advocacy and partnering on systems levels with the health sector.

This survey provides useful evidence of broad and complex health needs. The Alliance in its Health Initiative will build on this baseline to develop, implement, and evaluate promising models. More research on the integration of health services in DV interventions, as well as evaluation research on medical-advocacy models is needed to support our work.

KEY INFORMANT INTERVIEWS & DOCUMENT REVIEW

The Health Survey tool was reviewed by FJC Directors and survey administrators at participating FJCs and feedback was provided to the Alliance. We also analyzed current FJC intake and assessment forms to understand how and if health issues are assessed and integrated into services. Open coding revealed the following themes:

EXTENSIVE SCOPE

The survey was purposefully extensive in order to capture a whole health history. However, FJC staff noted that the stage of crisis, reason for the visit, and familiarity with the FJC as factors in completing the survey. Key assessment questions need to be identified and adopted into practice.

LITERACY & DELIVERY METHOD

The environment and method in which health screening questions are delivered is important; self-reported screenings should be followed-up orally by advocates to clarify answers and needs.

STAGING

Survivors new to the FJC may not have developed the necessary rapport to divulge personal health information. Similarly, survivors in immediate crisis may not prioritize their health concerns within the context of trauma. Health assessments should be integrated into case management and advocacy services where advocates, counselors, and/or medical staff can phase both their assessment and methods of support for survivors' health.

STAFF/ADVOCATE HEALTH KNOWLEDGE & SKILLS

Advocates and FJC staff are experts in supporting the changing priorities of needs that survivors bring forward. Advocates demonstrate high skill and high self-efficacy in identifying mental health, and basic needs. More training on non-acute health needs and chronic disease risk factors is needed.

INTAKE & ASSESSMENT PRACTICES

FJC intake generally assesses health needs through 1) referrals from/to a hospital/clinic, 2) request for specific health services, and 3) conducting the Danger

Key Findings

- **The scope of questions should be tailored**
- **Rapport and trust is needed before survivors will disclose health issues, especially mental health or substance abuse issues.**
- **Advocates and staff need to follow-up on questionnaires orally to clarify health needs.**
- **A person in crisis may not be ready to talk about health issues, therefore phasing-in support activities is important.**
- **Staff need and want training to build awareness of "unseen" health issues clients may be facing.**
- **Most partner agencies ask some health history questions, standardization, tracking, and referral protocols should be implemented.**

Assessment. Key health assessment questions should be standardized across Partner Agencies.

PROMISING MEDICAL MODELS

The following chart reviews the final list of viable medical models the Alliance recommends for development in FJC sites. These models were chosen based on evidence from the literature, our data findings, and feasibility within the FJC or a multi-disciplinary service agency model. The benefits, challenges, and evidence supporting each on- and off-site model are detailed.

ON-SITE			
MODEL	**BENEFITS**	**CHALLENGES**	**EVIDENCE**
HEALTH PARTNERSHIPS (E.G. COMMUNITY HEALTH CLINICS, RESIDENCY PROGRAMS)	+Build link to personal physician +Cross-training opportunities +Extra use of forensic medical units +Can link to ongoing advocacy/casework +Sustainable funding (CHC partner can bill services) +Potential for multiple partners, based on community resources (e.g. health provider from CHCs, residency programs, private practice, etc)	- Undocumented immigrants do not qualify for coverage - Building relationship with overburdened CHCs or Medical Schools - Need to guarantee patient flow	• CHCs provide primary care to >9 million disadvantaged Americans (Stargield & Shi, 2004). • Patient-centered medical home model has a team/coordination emphasis in line with FJCs (Health Affairs, 2010). • Having a Primary Care Provider (PCP) is the only factor related to receiving regular healthcare (Stargield & Shi, 2004).
HEALTH NAVIGATORS	+FJCs have navigators/caseworkers that can be trained +Cross-training opportunities between +Hospital/clinic and FJC navigator programs +Can link to ongoing advocacy/casework +Health insurance enrollment	- Still need to make referral and link to health care site - Building relationships with health partners - No direct medical/health services on-site	• Nurse Coordinators/Navigators have decreased readmission rates, improved patient adherence, and strengthened patient-provider relations in hospital settings (Health Affairs, 2013). • Pilot studies have shown that advocates ("IPV interventionists") increased screening and disclosure rates in clinics (Rhodes et al., 2013)
FORENSIC MEDICAL UNITS	+Medical professionals already trained/sensitive to issues of violence +Can link to ongoing advocacy/casework +Many FJCs and/or community clinics have forensic units available	- SART/SANE nurses not necessarily connected to broader health system - Need to train and engage advocates in health issues - Need to engage nurses in ongoing advocacy - Only reimbursed for SA, not DV - Not all are capable of evaluating children	• Documenting DV in medical health records may assist in DV cases (Isaac & Enos, 2001). • Training for providers on trauma and forensics remains limited (Barefoot & Galvan, 2003). • Forensic units and documentation for DV (similar to SA) is expanding in Coalition/Hospital partnerships (MNADV, 2012). • New York State (Bill S1593-2013) passed laws to expand use of forensic medical units.

SEXUAL ASSAULT RESPONSE TEAM (SART) EXPANSION	+Builds on collaborative model of SARTs and FJCs +Creates opportunities for case-review, cross-training, and collaboration building +Can utilize intake specialists at FJCs to coordinate SART (both case management and team meeting coordination) +Provides trauma-informed care	- SANE nurse must be hired/trained by hospital/clinic if not already available - Conflict due to different organizational goals of partners. - Intake specialists need experience or training. - A Coordinator or technical assistance may be necessary to manage the program.	• SART programs have improved relationships among participating stakeholders, increased victim participation in legal proceedings, improved quality of legal evidence, improved legal outcomes, and decreased re-traumatization among victims (Greeson & Campbell, 2012). • Technical assistance is important in bridging any organizational gaps (Greeson & Campbell, 2012). • The National Institute of Justice released a study report demonstrating that SARTs with high levels of formalization, within and across sector collaboration, and that participated in program evaluation were most successful (Campbell et al., 2013). • Components of leadership, stakeholder relationships, and collaborative structure are key concepts in collaborative DV organizations and teams (Nowell, 2009; Campbell et al., 2013)
OFF-SITE			
MODEL	**BENEFITS**	**CHALLENGES**	**EVIDENCE**
MOBILE HEALTH CLINIC	+Broader reach/service area +Builds link to personal physicians +Cost-effective health service alternative	- Need to create link/bridge to advocacy. - Procuring and maintaining mobile unit.	• Effectively addressed asthma and other health disparities among school-aged children. • An effective alternative model of school-based health centers (Bollinger, Morphew & Mullins, 2010). • Has shown 36:1 return on investment in reducing ER visits ($3million) (Oriol et al., 2009). • The combination of outreach and hot-spotting (indentifying areas of specific need) have been used to address emergency room users, Medicaid-paid births (Hardt et al., 2013), and high-concentration areas of violence (OCDV, 2012).
HOME VISITATION	+Already a component of child protection services and public health nursing projects. +Intensive one-on-one assistance in all social and health needs +Potential links to long-term health services	- Child protective programs have a focus on child/family – mother's needs are secondary - Need strong partnerships for referral for mothers - Issues of mandated-	• Nurse Family Partnership (an evidence based public health nursing model for new mothers) showed improved outcomes for reproductive health concerns, addressed risks of increased violence, and improved nurse/victim relations in a pilot study with an emphasis on IPV screening and care (Jack et al., 2012).

PROGRAM	(link to healthcare, insurance enrollment, etc.) +Collaborative grants between evidence based programs and FJCs are available.	medical reporting and nurse/caseworker comfort in identifying, assessing, and discussing IPV - Difficult to maintain/expand large caseloads (individualized approach)	• -Addressing IPV is still a sensitive issue with home-visitor programs – there is potential to reduce likelihood for disclosure (especially in child welfare programs) (Davidov et al., 2012)
WARM REFERRALS	+Partnership building +Opportunities to link advocacy and practice trauma-informed care +Established via MOU (i.e. easily sustainable)	- Potential for re-traumatization - Need established protocols for treating the referral - May be difficult to establish with already overburdened, service-oriented, Community Health Centers	• WHO Clinical Guidelines (2013) recommend warm referrals as a standard practice of "woman-centered care". • Theories of Stakeholder engagement emphasize involving a variety of stakeholders, and identify their role and value early on in program development. • Warm referrals have been used for a variety of low-enrollment programs within healthcare (Richter et al., 2012).
MOBILE TECHNOLOGY HEALTH PLATFORMS	+Provides options for +Centers with limited health resources +Compatible with the +ACA's emphasis on expanding health information technology, including electronic health records, health portals, etc.	- Expensive technology - Privacy and confidentiality concerns - Mandated medical reporting - May need an in-person follow-up to handle linkage to advocacy after disclosure, or link to long-term care after initial screening.	• Promising practice – little outcome evaluation evidence to date. • Computer-based IPV screening increased rates of disclosure and improved consistency of screening in one pilot study (Post et al., 2013). • Provider follow-up after disclosure was most helpful in making successful links to care (Post et al., 2013). • The ACA is supporting the expansion of electronic medical records (EMRs) and health information technology (HIT, such as patient portals).

RECOMMEDATIONS & ACTION STEPS

SCREENING AND ADVOCACY

Advocates need additional training in recognizing, assessing, and providing support for non-acute health needs and chronic disease risk factors in IPV survivors. Resources and pathways to these resources need to be established. Similarly, relationships between the health and advocacy systems need developing to monitor and assess high risk cases, as well as ensure the take-up of screening, and creation of strong linkages with health services after crisis intervention efforts.

PROGRAMMING

Innovation is needed to identify and test best and promising practices for reaching survivors and their families, and providing for their basic and whole health needs. Similar to Fatality Review Teams and Sexual Assault Response Teams, coordinated, multi-disciplinary teams for frequent-ER users or patients who disclose abuse may be an important component of health programs. Outreach programs into communities are needed to loop "unidentified" victims into care.

COLLABORATION

While both advocacy and health systems share missions for improved quality of life, safety, and health, the systems remain separate and distinct. More work to produce cross-sector collaboration models is needed. On-site health services are feasible at FJC sites through a variety of models, depending on the community health resources available. Such expansion should also include partnership building and cross-training with the health sector for broader impact and closer working relationships.

POLICY

The Patient Protection and Affordable Care Act may not provide the necessary protection for our most vulnerable victims: immigrants, homeless, and indigent populations. The Violence Against Women Act, pending Immigration Reform, and other federal and state laws need to address this gap and ensure the right to health and safety for these groups.

TAKE THE FIRST STEP: Recommendations for FJCs and other Multidisciplinary DV Organizations

- **Engage the health sector as new partners:** Departments of Health, Health and Human Services Administration, local Hospitals and/or community health clinics, etc.
- **Include key health questions into intake and partner agency assessment:**
  - Do you currently have a primary care provider?
  - Have you been the ER in the last year?
  - Do have health insurance/have you enrolled for health insurance under the ACA?

  *Resources to address these questions need to be available.
- **Establish protocols to expand assessment and support options** for health concerns during follow-up, or after periods of crisis/trauma.
- **Train staff and volunteers** on non-acute and chronic health issues related to DV.
- **Establish a community Task Force** on Health and DV to tailor future programs and action steps for a FJC or community-based agency

FUTURE WORK

Moving forward, the Alliance is partnering with select FJC sites to document their current health services and assist and evaluate service expansion using the models described above. A pilot project is underway with the Valley Cares Family Justice Center in Los Angeles, California to evaluate potential expansion of a SART Program in a Family Justice Center to better address health needs of IPV survivors. The Alliance is also analyzing potential expansion of a Forensic Medical Unit model currently in operation at the Erie County Family Justice Center in Buffalo, New York.

The Alliance will present findings and provide detailed toolkits and/or resources at our 2014 Annual International Family Justice Conference. We will continue to provide technical assistance to these and other FJCs looking to create or expand on-site health services. Our goal is to provide trainings, host health forums/conference, facilitate information exchange, provide programmatic tools and resources, and support the capacity of FJCs to assess and provide for the whole health needs of survivors. Furthermore, on a systems-level, the Alliance is positioned to connect the health and DV sectors through partnerships and policies.

By integrating the needs of domestic violence survivors into new health delivery models, there is great potential to increase disclosure and formal help-seeking, and address disparities in health and safety facing our communities. Addressing long-term chronic health issues is critical but must be addressed in the context of a structured, sustainable health services model in FJCs.

We invite you to join us through your FJC or community-based domestic violence agency as we strive to better serve survivors of IPV in addressing their health care needs.

CONTACT INFORMATION
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Public Health Program Associate
619.573.4543
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Family Justice Center Alliance
HEALTH NEEDS SURVEY

Date: _____

This is a survey to help the Family Justice Center Alliance understand more about the health needs of our clients.
The survey is completely voluntary and confidential.
You do not have to answer any question that makes you feel uncomfortable.

Demographics

Age	Gender	Ethnicity	Primary Language	Employment Status	Education
_____ *years*	☐ Female ☐ Male ☐ Transgender ☐ Other	☐ American Indian / Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latina ☐ Native Hawaiian / Pacific Islander ☐ White ☐ Multiracial ☐ Other:_____	☐ Arabic ☐ ASL ☐ Cambodian ☐ English ☐ French ☐ Korean ☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese ☐ Other: _____	☐ Not working ☐ Student ☐ Seasonal/temporary ☐ Military ☐ Working part-time ☐ Working full-time	☐ Less than high school ☐ High school diploma/GED ☐ Some college ☐ Completed college ☐ Advanced/professional degree

Do you have children?	Are you pregnant?	Were you born in the United States?	How long have you been coming to this Family Justice Center?
☐ Yes ☐ No **How many currently live with you? _____**	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No	☐ This is my first visit ☐ I come for occasional services ☐ I use on-going services (therapy, etc.)

Insurance Coverage

1. Do you currently have health insurance coverage?

☐ Yes, through my work
☐ Yes, through someone else's work (like a spouse or parent)
☐ Yes, I purchase private insurance
☐ Yes, I have public or state insurance (Medicaid, Medicare)
☐ Yes, I have Indian Health Service coverage
☐ Yes, through the military
☐ No, I do not currently have any insurance

2. **If yes, what does your insurance cover**? *Check all that apply* ☐ Health ☐ Vision ☐ Dental ☐ Don't know / not sure

3. **In general, how would you rate your health?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

4. **Do you have a primary care doctor?** ☐ Yes ☐ No Date of last visit? _____ *(month/year)*

5. Have you experienced or has a doctor told you that you have any of the following *PHYSICAL HEALTH* conditions?

☐ Headaches	☐ Heart disease or heart attack	☐ High Blood Pressure	☐ Physical injury: _____
☐ Fatigue	☐ Thyroid problems	☐ Diabetes	☐ Frequent colds/flues
☐ Constant pain	☐ Liver disease	☐ Asthma	☐ Physical disability
☐ Stomach ulcers	☐ Arthritis	☐ Emphysema	☐ Hearing loss
☐ Head trauma	☐ Cancer: type:_____	☐ Irritable Bowel Syndrome	☐ Other:_____

6. Have you experienced or has a doctor told you that you have any of the following *SEXUAL HEALTH* conditions?

☐ Sexually Transmitted Diseases (e.g. Chlamydia, Gonorrhea)	☐ Vaginal Infections	☐ Urinary Tract Infections (bladder infections)	☐ Other: _____
☐ HIV/AIDS	☐ Pelvic Pain	☐ Problems with pregnancy	
	☐ Painful Intercourse (sex)		

7. Are any of the above health concerns related to your experience of violence?
☐ Yes ☐ No ☐ Don't know

8. Have you received treatment for any of these health concerns in the <u>past 12 months?</u>
☐ Yes ☐ No ☐ N/A

9. Is anything preventing you from receiving or following up with treatment? *(Check all that apply)*

☐ No, I receive regular care
☐ Too expensive
☐ Transportation is difficult
☐ No insurance / insurance does not cover
☐ Clinic hours, scheduling, or wait times are hard for me
☐ Other _____

10. **Have you gone to the Emergency Room in the <u>last 12 months?</u>** ☐ Yes ☐ No

11. Have you been prescribed medication in the *last 12 months*? □ Yes □ No

12. **If yes, are there any barriers to taking your medication as your doctor instructed?** (*Check all that apply)*

□ Too expensive
□ Transportation (it is difficult to travel to a pharmacy)
□ No insurance / Insurance does not cover
□ I am not sure how I need to take it
□ Other:_____

13. Are you currently using a birth control method (condoms, birth control pills, etc.)?

□ Yes, regularly □ No, but I would like to receive services □ No, not interested □ N/A

Psycho/Social History

14. **In general, how would you rate your mental health?** □ Excellent □ Good □ Fair □ Poor

15. **Have you experienced any of the following *MENTAL HEALTH* symptoms?** *Check all that apply*

□ Anxiety
□ Panic Attacks
□ Anger/Temper
□ Low Self-Esteem
□ Changes in Appetite
□ Hearing Voices
□ Changes in sexual desire
□ Long periods of sadness / depression
□ Difficulty controlling behavior
□ Difficulty controlling emotions
□ Avoiding people or situations
□ Trouble Sleeping (insomnia)
□ Nightmares
□ Flashbacks
□ Other: _____

16. Are any of the above mental health concerns related to your experience of violence?

□ Yes □ No □ Don't know

17. Have you gone to see a mental health professional for these symptoms in the *past 12 months*?

□ Yes □ No □ N/A

18. Is anything preventing you from receiving or following up with MENTAL HEALTH care?

□ No, I receive regular care
□ Too expensive
□ Transportation is difficult
□ No insurance / insurance does not cover
□ Clinic hours, scheduling, or wait times are hard for me
□ Other _____

19. On average, how many *days per week* do you drink alcohol?

□ I do not drink alcohol □ 1 day □ 2 days □ 3 days □ 4 days □ 5 days □ 6 days □ 7 days

20. On a typical drinking day, how many drinks do you have?

□ I do not drink alcohol □ 1 drink/day □ 2 drinks/day □ 3 drinks/day □ 4 drinks/day □ 5+ drinks/day

21. On average, how many *days per week* do you use recreational drugs (marijuana, cocaine, prescription drugs, etc..)?

□ I do not use recreational drugs □ 1 day □ 2 days □ 3 days □ 4 days □ 5 days □ 6 days □ 7 days

22. Do you smoke?

□ No, never □ 1-5 cigarettes ***per week*** □ 1-5 cigarettes ***per day*** □ ½ pack per day □ 1 pack per day □ 1+ pack per day

23. Do you have any difficulty getting around or performing daily tasks due to physical, mental, or emotional health?

□ Yes □ No

24. If yes, do you have someone (family, friend, professional) who helps you with your health needs?

□ Yes □ No

Dental/Vision

25. Do you have any current DENTAL concerns?

□ Cavities
□ Gum sensitivity or bleeding
□ Frequent tooth pain
□ Tooth abscess (root pain and infection)
□ Tooth decay
□ Broken or missing teeth
□ Other: _____

26. **Have you gone to see a DENTIST in the *past 12 months*?** □ Yes □ No

27. **Is anything preventing you from receiving or following up with DENTAL care?** *(Check all that apply)*

□ No, I receive regular care
□ Too expensive
□ Transportation is difficult
□ No insurance / insurance does not cover
□ Clinic hours, scheduling, or wait times are hard for me
□ Other _____

28. Do you have any current VISION / EYE problems?

□ Near sighted / far sighted
□ Astigmatism (blurred vision)
□ Glaucoma
□ Retinal detachment/tearing
□ Sudden loss of vision
□ Partial/full blindness
□ Other:_____

29. **Have you gone to see an EYE DOCTOR in the *past 12 months*?** □ Yes □ No

30. **Is anything preventing you from receiving or following up with VISION / EYE care?** *(Check all that apply)*

☐ No, I receive regular care
☐ Too expensive
☐ Transportation is difficult
☐ No insurance / insurance does not cover
☐ Clinic hours, scheduling, or wait times are hard for me
☐ Other _____

31. Are any of the above DENTAL AND/OR EYE health concerns related to your experience of violence?

☐ Yes ☐ No ☐ Don't know

Preventative Health

32. Have you received any of the following *HEALTH SCREENINGS OR EXAMS* within the *last 12 months*?

☐ Regular dental cleanings/check-ups
☐ Regular vision screenings
☐ Pap Smear
☐ Flu vaccine (shot or nasal spray)
☐ Mammogram (breast cancer test)
☐ HPV vaccine (cervical cancer or genital warts vaccine)
☐ Breast exam (self or provider administered)
☐ Blood pressure screening
☐ Cholesterol screening
☐ Other: _____

33. On average, how many days *per week* do you take part in physical activity or exercise *for at least 30 minutes*?

☐ 0, I do not exercise ☐ 1day ☐ 2days ☐ 3days ☐ 4days ☐ 5days ☐ 6days ☐ 7days ☐ Don't know / Not sure

34. During the past 30 days, how often did you drink regular soda or pop, or other sugary juices or drinks (do not include diet soda or 100% fruit juice)?

☐ More than once a day ☐ Once a day ☐ 1-2 times per week ☐ A few times (less than 5) in the past 30 days

35. Of all the services available at this FJC, what are your MOST IMPORTANT needs?

Check the **TWO** most important:

☐ Social services (housing, public assistance, etc)
☐ Civil or Legal services (restraining orders, court advocacy, etc)
☐ Services for my children
☐ Healthcare
☐ Counseling or therapy
☐ Other: _____

36. What health related services, if any, would you like the Family Justice Center to offer?

☐ Vision / eye care
☐ Dental care
☐ Women's health / reproductive health
☐ Primary care
☐ Well-baby check-ups
☐ Immunizations / vaccines
☐ Health insurance enrollment
☐ Preventive health screenings (mammograms, etc.)
☐ Mental health
☐ Substance Abuse Counseling
☐ Chronic Disease management (Diabetes, high blood pressure, etc)
☐ Nutrition
☐ Holistic health (yoga, meditation, etc.)
☐ Health Education
☐ Other: _____

37. Would you like health information and / or services for your children?

☐ Yes ☐ No ☐ N/A

38. Any other comments about how the FJC can serve the health needs of survivors?

THANK YOU!
We appreciate your assistance with this survey.

Please return this survey to the DESIGNATED, CONFIDENTIAL AREA.
Questions? Please ask an FJC Staff Member or Advocate.

All information will remain completely confidential.

Family Justice Center Alliance

CUESTIONARIO DE SALUD

Fecha: _____

Este es un cuestionario para ayudar a la Alianza de Centros de Justicia para la Familia conocer más acerca las necesidades de salud de nuestros clientes. ***El cuestionario es completamente voluntario y confidencial.***

Usted no tiene que responder cualquier pregunta que le haga sentir incómodo.

Información Demográfica

Edad	Género	Origen étnico	Idioma Principal	Estado de Empleo	Nivel de Educación
_____ *años*	☐ Mujer ☐ Hombre ☐ Transgénero ☐ Otro	☐ Indio Americano / nativo de Alaska ☐ Asiático/ Islas del Pacífico ☐ Afro-americano ☐ Hispano/Latino ☐ Nativo de Hawái / Islas del Pacífico ☐ Blanco ☐ Multirracial ☐ Otro:_____	☐ Árabe ☐ ASL ☐ Camboya ☐ Inglés ☐ Francés ☐ Coreano ☐ Ruso ☐ Español ☐ Tagalog ☐ Vietnamita ☐ Otro:_____	☐ No trabajo ☐ Estudiante ☐ Trabajo Temporal ☐ Militar/Ejercito ☐ Trabajo tiempo parcial (menos de 40 horas) ☐ Trabajo tiempo completo (40 horas o más)	☐ Menos que la secundaria ☐ Diploma de la secundaria / GED ☐ Poca universidad ☐ Graduado de la universidad ☐ Título profesional

¿Tiene niños?	Está embarazada?	¿Nació en los Estados Unidos?	¿Cuánto tiempo ha estado viniendo a este Centro de Justicia para la Familia?
☐ Sí ☐ No **¿Cuántos viven con usted? _____**	☐ Sí ☐ No ☐ No sé	☐ Sí ☐ No	☐ Primera visita ☐ Vengo a veces por servicios ☐ Uso servicios regularmente (consejería, etc.)

Seguro Medico

39. ¿Tiene seguro médico?

☐ Sí, a través de mi trabajo
☐ Sí, a través del trabajo de otro (marido, padres, etc.)
☐ Sí, compro seguro privado
☐ Sí, a través del Estado / gobierno (Medicaid, Medicare)
☐ Sí, a través del Servicio de Salud para los Indios
☐ Sí, a través del ejercito
☐ No, no tengo seguro medico

40. **Si tiene seguro, ¿que cubre**? *(Marque todas que correspondan)* ☐ Salud ☐ Visión ☐ Dental ☐ No sé

41. **En general, ¿cómo calificaría su salud?** ☐ Excelente ☐ Buena ☐ Normal ☐ Mala

42. **¿Tiene un médico primario?** ☐ Sí ☐ No Ultima visita (fecha)? _____ *(mes/año)*

43.¿Ha sentido, o tiene un médico que le haya dicho que usted tiene cualquiera de las siguientes CONDICIONES FISICAS?

☐ Dolor de cabeza	☐ Enfermedad cardiovascular	☐ Hipertensión / tensión alta	☐ Heridas físicas: _____
☐ Cansancio/agotamiento	☐ Problemas de tiroides	☐ Diabetes	☐ Resfriados /gripas frecuentes
☐ Dolor constante	☐ Enfermedad hepática	☐ Asma	☐ Discapacidades físicas
☐ Ulceras en el estómago	☐ Artritis	☐ Enfisema	☐ Pérdida de oír
☐ Trauma en la cabeza	☐ Cáncer: tipo:_____	☐ Síndrome de colon irritable	☐ Otro(s):_____

44. ¿Ha sentido, o tiene un médico que le haya dicho que usted tiene cualquiera de las siguientes CONDICIONES SEXUALES?

☐ Enfermedad de transmisión sexual (ej. Clamidia, Gonorrea)	☐ Infección vaginal	☐ Infección urinaria	☐ Otro(s): _____
☐ VIH/SIDA	☐ Dolor pélvico	☐ Complicaciones de embarazo	
	☐ Coito doloroso		

45. **¿Alguno de estos problemas son causados por su abuso?**
☐ Sí ☐ No ☐ No sé ☐ Prefiero no decir

46. **¿Ha recibido tratamiento para cualquiera de estos problemas de salud en los <u>últimos 12 meses</u>?**
☐ Sí ☐ No ☐ N/A

47. ¿Algo le impide recibir o seguir con el tratamiento de estos problemas? *(Marque todo que corresponda)*

☐ No, yo recibo tratamiento regular
☐ Muy caro
☐ Transporte es difícil
☐ No tengo seguro / seguro no cubre
☐ Horas de operación de la clínica, o tiempo de espera es muy difícil
☐ Otro(s) _____

48. **¿Ha ido a la sala de emergencia en los <u>últimos 12 meses</u>?** □ Sí □ No

49. ¿Le han recetado medicamentos en los <u>últimos 12 meses</u>? □ Sí □ No

50. **Si respondió sí ¿existen obstáculos para tomar su medicamentos como su médico le indico?**
(Marque todo que corresponda)

□ Muy caro
□ Transporte es difícil
□ No tengo seguro / seguro no cubre
□ No estoy segura como tengo que tomar los medicamentos
□ Otro(s):_____

51. ¿Tiene método de control de natalidad (condones, píldoras de método anticonceptivo, etc.)?
□ Sí, uso un método regular □ No, pero me gustaría servicios □ No, no tengo interés □ N/A

Historia Psicológica

52. **En general, ¿cómo calificaría su salud mental?** □ Excelente □ Buena □ Normal □ Mala

53. **¿Ha tenido cualquiera de los siguientes síntomas de SALUD MENTAL?**

□ Ansiedad
□ Ataque de pánico
□ Mal humor / ira
□ Baja autoestima
□ Cambios de apetito
□ Oír voces
□ Cambios en deseo sexual
□ Largos períodos de tristeza(depresión)
□ Dificultad en controlar comportamientos
□ Dificultad en controlar emociones
□ Evitar el contacto con personas o lugares
□ Insomnio
□ Pesadillas
□ Recuerdos recurrentes
□ Otro(s):_____

54. **¿Alguno de estos problemas son causados por su abuso?**
□ Sí □ No □ No sé □ Prefiero no decir

55. **¿Ha ido a ver un profesional de la salud mental (consejero) por estos síntomas en los <u>últimos 12 meses</u>?**
□ Sí □ No □ N/A

56. ¿ Algo le impide recibir o seguir con el tratamiento de estos problemas de la SALUD MENTAL?
(Marque todo que corresponda)

□ No, yo recibo tratamiento regular
□ Muy caro
□ Transporte es difícil
□ No tengo seguro / seguro no cubre
□ Horas de operación de la clínica, o tiempo de espera es muy difícil
□ Otro(s) _____

57. En general ¿cuántos días a la semana usted toma bebidas alcohólicas?
□ 0, yo no tomo □ 1 día □ 2 días □ 3 días □ 4 días □ 5 días □ 6 días □ 7 días

58. En un día típico, ¿cuántas bebidas alcohólicas tiene?
□ 0, yo no tomo □ 1 bebidas/día □ 2 bebidas/día □ 3 bebidas/día □ 4 bebidas/día □ 5+ bebidas/día

59. En una semana típica, ¿cuántos días a la semana utiliza drogas (marihuana, cocaína, medicinas recetadas, etc.)?
□ 0, yo no uso drogas □ 1 día □ 2 días □ 3 días □ 4 días □ 5 días □ 6 días □ 7 días

60. **¿Usted fuma?**
□ No fumo □ 1-5 cigarrillos por semana □ 1-5 cigarrillos al día □ ½ paquete al día □ 1 paquete al día □ 1+ paquete al día

61. ¿Tiene dificultades con actividades diarias debido a la salud física, mental o emocional?
□ Sí □ No

62. Si respondió sí, ¿tiene alguien (familia, amigo, otra) que le ayuda?
□ Sí □ No

Dental/Visión

63. ¿Ha tenido cualquier problema con su SALUD DENTAL?

□ Caries
□ Sensibilidad o sangriento de las encías
□ Dolor de los dientes
□ Absceso (infección del diente)
□ Falta de dientes o diente partido
□ Otro(s): _____

64. **¿Ha ido a ver un dentista en los <u>últimos 12 meses</u>?** □ Sí □ No

65. **¿Algo le impide recibir o seguir con el tratamiento de la SALUD DENTAL?** *(Marque todo que corresponda)*

□ No, yo recibo tratamiento regular
□ Muy caro
□ Transporte es difícil
□ No tengo seguro / seguro no cubre
□ Horas de operación de la clínica, o tiempo de espera es my difícil

☐ Otro(s) _____

66. ¿Ha tenido cualquier problema de SALUD OCULAR (o de visión)?

☐ Miope / Hipermetropía
☐ Astigmatismo (visión nublado)
☐ Glaucoma
☐ Desprendimiento de la retina
☐ Pérdida súbita de la visión
☐ Ceguera total / parcial
☐ Otro(s):_____

67. **¿Ha ido a ver un oftalmólogo / oculista en los <u>últimos 12 meses?</u>** ☐ Sí ☐ No

68. **¿Algo le impide recibir o seguir con el tratamiento de la SALUD OCULAR?** *(Marque todo que corresponda)*

☐ No, yo recibo tratamiento regular
☐ Muy caro
☐ Transporte es difícil
☐ No tengo seguro / seguro no cubre
☐ Horas de operación de la clínica, o tiempo de espera es my difícil
☐ Otro(s) _____

69. **¿Alguno de estos problemas de su SALUD DENTAL U OCULAR son causados por su abuso?**
☐ Sí ☐ No ☐ No sé ☐ Prefiero no decir

Salud Preventiva

70. ¿Ha recibido los siguientes DIAGNOSITICO / EXAMENES DE SALUD en los <u>últimos 12 meses</u>?

☐ Limpieza de dientes y consultas con un dentista
☐ Diagnósticos y consultas de visión
☐ Papanicolaou / o consultas de salud sexual
☐ Vacuna contra la gripe
☐ Vacuna Contra el Virus de Papiloma Humano (VPH)
☐ Mamografía o mamograma (por medico o autoexamen)
☐ Diagnóstico de presión arterial
☐ Diagnóstico de colesterol
☐ Otro(s):_____

71. **En una semana típica, ¿Cuanto días a la semana hace ejercicio físico por <u>lo menos 30 minutos</u>?**
☐ 0, yo no hago ejercicio ☐ 1 día ☐ 2 días ☐ 3 días ☐ 4 días ☐ 5 días ☐ 6 días ☐ 7 días ☐ No sé

72. En los últimos 30 días, ¿Con qué frecuencia ha bebido una soda/ gaseosa, jugo azucarado, o otras bebidas azucaradas (no incluyen sodas dietas o jugo de 100% fruta)?
☐ Más de una vez al día ☐ Una vez al día ☐ 1-2 veces al semana ☐ Menos que 5 veces en los últimos 30 días

73. **De todos los servicios disponibles en el Centro, ¿cuáles son sus necesidades MÁS IMPORTANTES?**
Marque los **DOS (2)** servicios más importantes.

☐ Servicios sociales (asistencia de vivencia, asistencia pública, etc.)
☐ Servicios legales (Orden de restricción, consejo para el corte)
☐ Servicios para los niños
☐ Servicios de la salud
☐ Terapia / consejería
☐ Otro(s): _____

74. ¿Qué servicios de salud, si cualquiera, le gustaría que ofrezca el Centro?

☐ Visión / ocular
☐ Tratamiento dental
☐ Salud para mujeres / salud reproductiva
☐ Atención primaria
☐ "Well-baby" – para infantes
☐ Inmunizaciones / vacunas
☐ Inscribirse en seguro medico
☐ Diagnósticos de salud (mamografías, etc.)
☐ Salud mental
☐ Consejería contra el abuso de sustancias
☐ Manejo de enfermedad crónica (Diabetes, presión alta, etc.)
☐ Nutrición
☐ Salud holística (yoga, meditación, etc.)
☐ Promoción y educación de la salud
☐ Otro(s): _____

75. **¿Quisiera información o servicios de salud para los niños?**
☐ Sí ☐ No ☐ N/A

76. **Otros comentarios sobre como el Centro puede servir las necesidades de salud para todos que vienen?**

¡¡MIL GRACIAS!!
Agradecemos su ayuda en este cuestionario.

Por favor, devuelva el cuestionario al área designada.
<u>Toda su información se mantendrá confidencial.</u>

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