National Family Justice Center Alliance

February 19, 2014 Webinar

Presenters:
Virginia Duplessis, MSW
Health Program Manager, Futures Without Violence
San Francisco, CA

Mercedes Hill
IPV Bilingual Health Advocate, HAVEN
The Dalles, OR

Ruth Miklem
Community Response Coordination Advocate, The Haven Shelter & Services
Warsaw, VA

Title: ***Integrating Health Services into Domestic Violence Programs***

Summary: Good health is an important step to healing from domestic violence, and advocates are in a unique position to intervene and reduce health consequences related to experiencing abuse. Integrating health services into domestic violence programs provides an important resource for clients to access resources and information, as well as an opportunity to create a culture of wellness and develop a more comprehensive array of services for their clients and staff. There are many models for integrating health services into domestic violence programs ranging from adding basic health assessments into shelter intakes, to creating full-scale onsite clinics and partnering with local health departments to station DV advocates in public health clinics. This webinar will include an overview of best practices and resources for advocates, as well as examples from the field.

As a result of attending this webinar, participants will be better able to:

- Assess the readiness of their programs to integrate health services into their programs
- Identify three tools/resources to integrate health services into domestic advocacy services
- Create partnerships with local health care providers

Welcome to the National Family Justice Center Alliance February Webinar!

While waiting for the presentation to begin, please read the following reminders:

- The presentation will begin promptly at 10:00 a.m. Pacific Time
- If you are experiencing technical difficulties, email natalia@nfjca.org
- To LISTEN to the presentation on your phone, dial (702) 489-0003, Access Code: 686-693-512 or listen on your computer speakers
- Attendees will be muted throughout the presentation
- To send questions to the presenter during presentation:
  - Click on "Questions" in the toolbar (top right corner)
  - Type your comments & send to presenter
- There will be a Q & A session at the end of the presentation.
- The presentation will be recorded & posted on www.familyjusticecenter.com
- Please complete the evaluation at the end of the presentation. We value your input.

Your hosts today:

Sara Wee, MPH
Public Health Associate

Natalia Aguirre
Director, Technical Assistance

Family Justice Center Alliance

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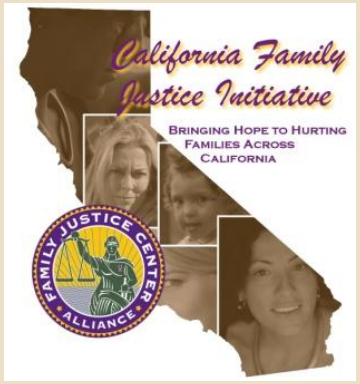

Thank you to the US Department of Justice, Office on Violence Against Women!

This project is supported all or in part by Grant No. 2012-TA-AX-K017 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

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Webinar Download Reminders

This webinar presentation is being recorded and will be posted on our website by close of business

If you would like to access our new Resource Library, please visit our website at www.familyjusticecenter.com and click on **“Resources”** tab → **“Resource Library”.**

Today's Presenters:

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Ruth Micklem
Community Response
Coordination Advocate,
The Haven Shelter & Services
Warsaw, VA

Anna Williams, MSW
Program Manager
HAVEN
The Dalles, OR

Integrating Health Services into Domestic Violence Programs

Part II

Recap

(CDC, 2013)

Health Initiative: An idea

Medical Expert Focus Group
Interviews with Front-line staff
Document Review
Health Needs Survey

Health Initiative: An idea

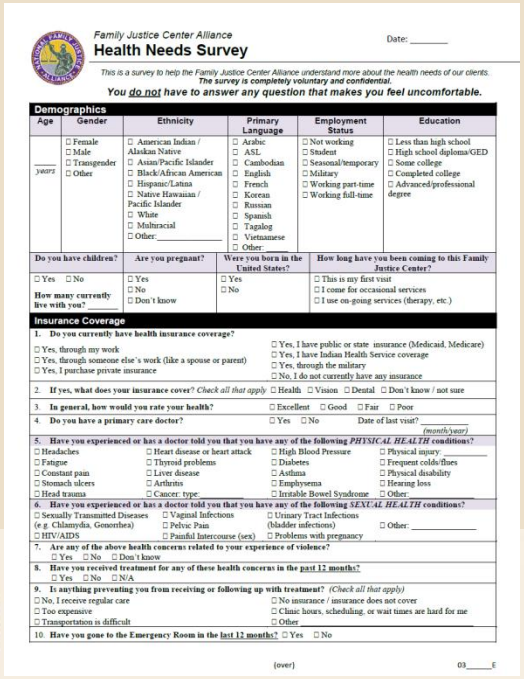
The purpose of our Health Initiative is to assess the health needs of survivors accessing FJC services, and use technical assistance to develop viable models for effective on- and off-site health services.

- ***Phase I: Study & Planning***
- ***Phase II: Pilot model testing***
- ***Phase III: Training & Technical Assistance***

Health Initiative: Survey

Survey Objectives

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



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) ☐ HIV/AIDS ☐ Vaginal Infections ☐ Pelvic Pain ☐ Painful Intercourse (sex) ☐ Urinary Tract Infections (bladder infections) ☐ Problems with pregnancy ☐ Other: _____
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 past 12 months?** ☐ 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 last 12 months?** ☐ Yes ☐ No

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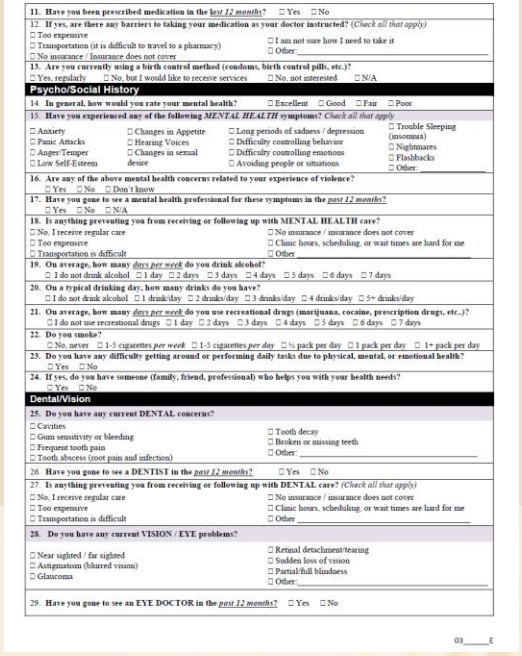

11. **Have you been prescribed medication in the *last 12 months*?** ☐ Yes ☐ No
12. **If yes, are there any barriers to taking your medication as your doctor instructed?** *(Check all that apply)*
    ☐ Too expensive
    ☐ Transportation (it is difficult to travel to a pharmacy)
    ☐ No insurance / 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?**
    ☐ 1 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?**
    ☐ 1 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..)?**
    ☐ 1 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

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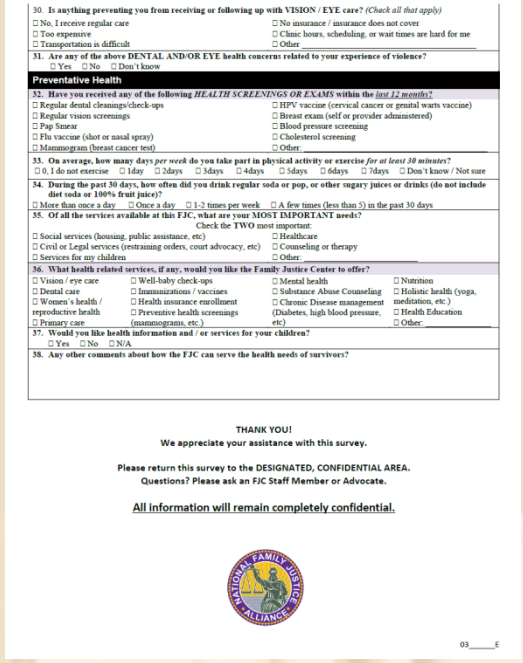

30. **Is anything preventing you from receiving or following up with VISION / EYE care?** *(Check all that apply)*
    ☐ No, I receive regular care
    ☐ Too expensive
    ☐ Transportation is difficult
    ☐ No insurance / insurance does not cover
    ☐ Clinic hours, scheduling, or wait times are hard 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.

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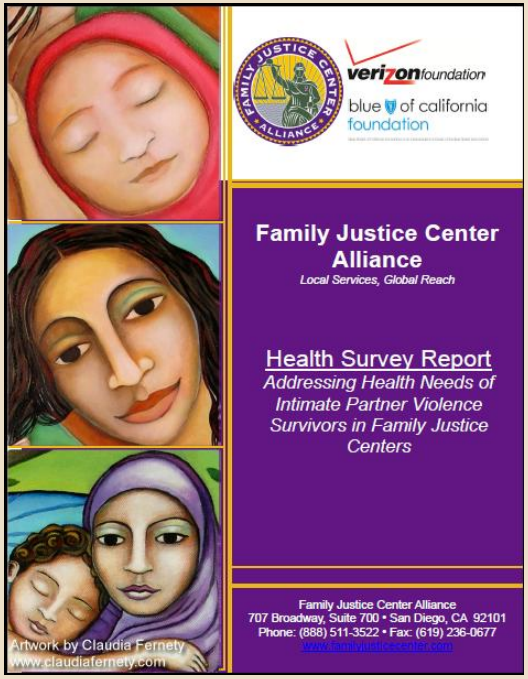
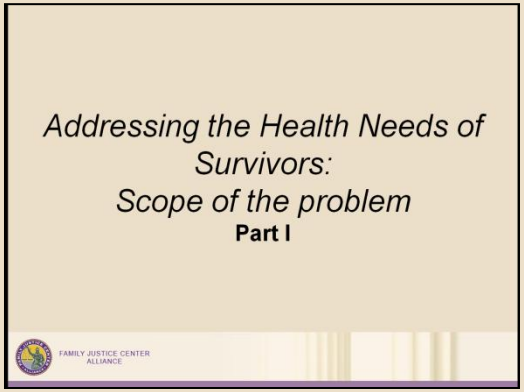
Health Survey Report



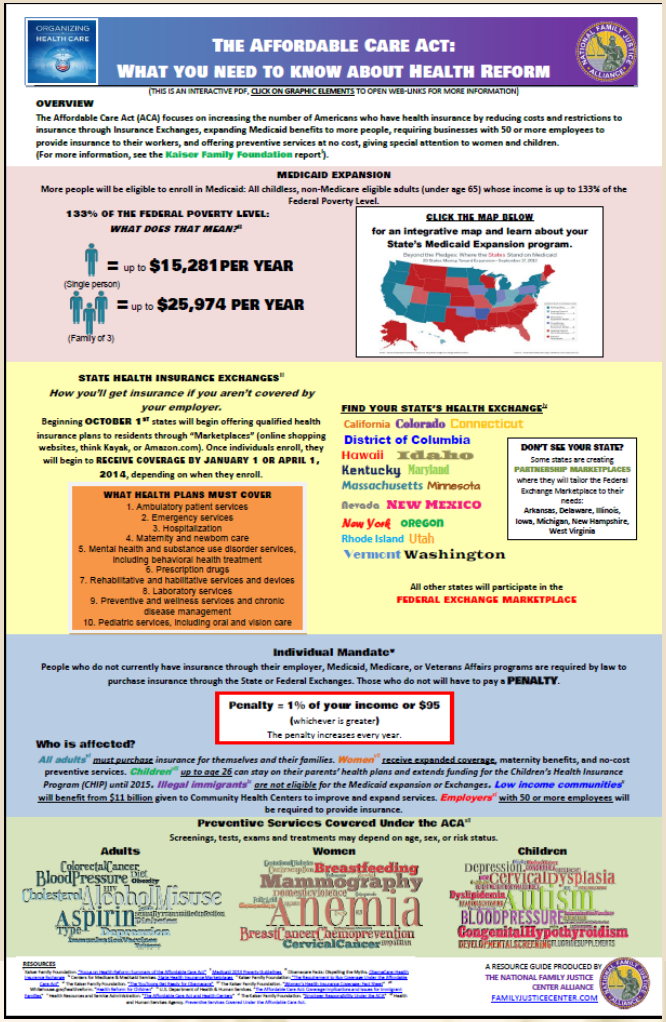
Released! Find it here!
Resource Library, under “Medical”.

Alliance Resources



Webinar: Part I, January 2014

FJC Directors Webinar



Info Graphic: What you need to know about the ACA

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Virginia Duplessis, MSW

FUTURES WITHOUT VIOLENCE®

Health Program Manager

FUTURES WITHOUT VIOLENCE®

Health Assessment as Safety Planning:

Integrating Health Services into Domestic Violence Programs

Learning Objectives

As a result of participating in this webinar, participants will be better able to:

1. Assess the readiness of their programs to integrate health services into their programs
2. Identify three tools/resources to integrate health services into domestic advocacy services
3. Create partnerships with local health care providers

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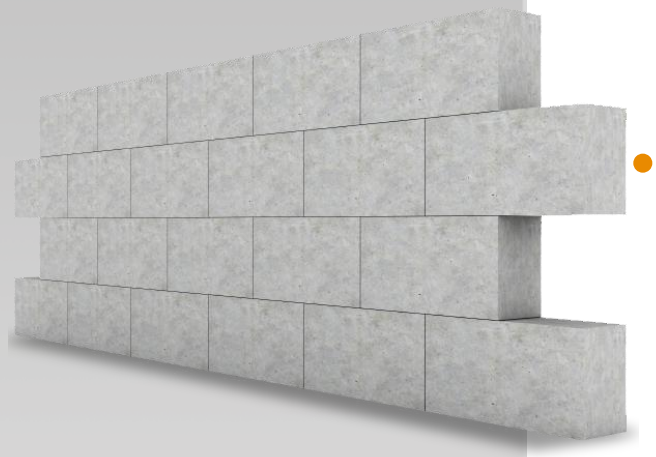
POLL #1

Barriers to Addressing Health Issues With Survivors



Identified by advocates:

- Scope of work
- Discomfort with initiating conversations
- What comes after disclosure?
- Lack of time

Health care providers identified the same barriers to addressing DV!

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17% of abused women reported that a partner prevented them from accessing health care

compared to **2%** of non-abused women

(McCloskey et al, 2007)

ACA and DV

- Screening and brief counseling for IPV as a covered preventive health service
- Training needs
- Increased referrals?

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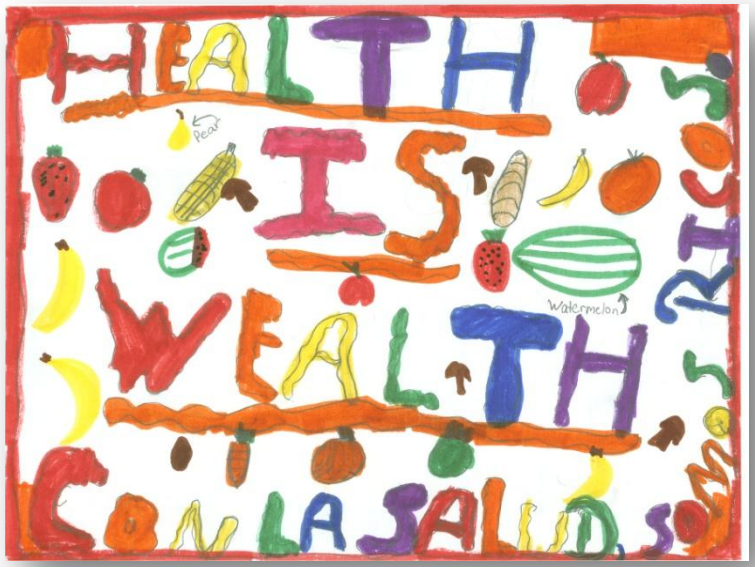
POLL #2

Opportunities for DV Programs

How is this related to your work?



- Good health is part of healing
- Opportunity to address health needs
- Unique position to intervene
- Reframe: DV program as wellness center

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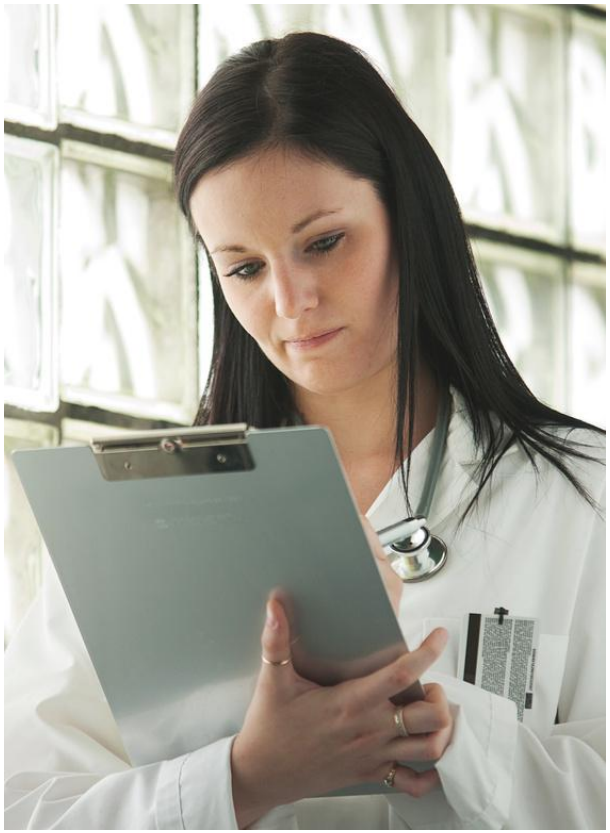
Providers want to partner with DV advocates to better serve their clients

"[Our] clinics are establishing productive and authentic partnerships with domestic violence centers. At last, we are getting the training and tools we need to address a fairly common but serious problem that has always been with us but has seldom received the attention it deserves."

Joe Fay, Statewide Coordinator
Alliance of Pennsylvania Councils



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Strategies: Onsite

- Add health questions to intake and case management forms
- Provide information on local health services
- Stock health supplies
- “Golden ticket” for appointments at local clinics
- Rx delivery by local pharmacy
- Clinical services
- Health education

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Strategies: Offsite

- Co-located advocate at local clinic
- On-call advocate with “backdoor” number
- Advocates trained in health services (translation, navigators, HIV care messengers, etc)

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POLL #3

Building relationships with local health programs

- Invitation to local DV taskforce and events
- Cross-trainings: DV 101 and healthcare 101
- Regularly stock program materials
- Program tour
- Clinic event (for patients &/or staff)

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Questions your program may have

- Making connections
- Getting buy in
- Formalizing partnerships
- Malpractice/insurance
- Records
- Funding/billing

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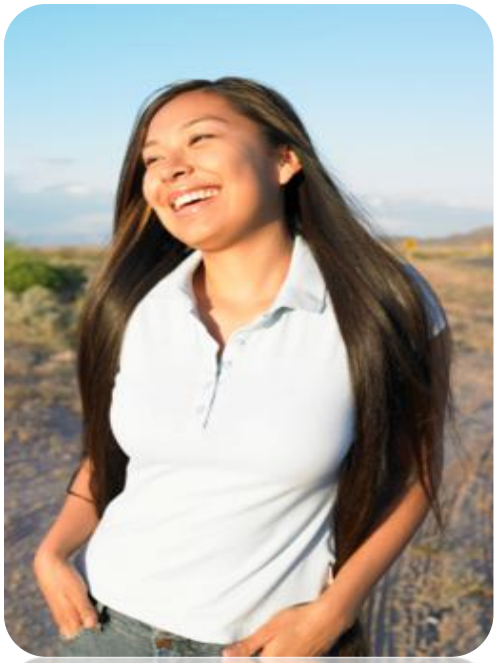
Voices of advocates

"For our women in shelter having access to medical services in a safe way without looking over their shoulder– it's part of rebuilding and taking control back. What do these medical resources mean to these women? They are priceless."



Sara Sheen, Director of Bridge Program
Rose Brooks Center, St Louis, MO

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Group Discussion

- What makes you a good advocate?
- What is the difference between asking about other needs (legal, housing, childcare, etc.) and health?
- What are the advocacy skills you would be putting to use when asking clients about health?
- What is your “worst case scenario” when thinking about discussing health issues with clients?

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Stories from survivors

According to the client, her abuser had sabotaged her birth control method in the past, forced her to terminate a pregnancy he didn't want, then forced her to keep a pregnancy that endangered her. …she said she felt relief to talk to someone about the coercive nature of her husband… she stated, "I'm so glad you asked me that."

- As reported by an advocate with a Virginia DV program

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Are you ready?

- What are the next steps your program can take to integrate health?
- What other information or training do you need?
- Do you know who your community health partners are?

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Resources through Futures

National Health Resource Center on Domestic Violence

- Training curricula
- Sample protocols, policies, MOUs, etc.
- Safety cards
- Posters
- Webinars and other training

  http://www.futureswithoutviolence.org/content/features/detail/790/

Online toolkit:
http://www.healthcaresaboutipv.org/

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Project Connect

A Coordinated Public Health Initiative
to Prevent Violence Against Women

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Thank you!

Ruth Micklem

Community Response Coordination Advocate

Warsaw, VA

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Project Connect Pilot Program

Goal:

Improve Shelter Based Health Services in Rural Domestic Violence Shelter

About:

The Haven Shelter and Services – SV/DV Agency

32 Bed Shelter in The Northern Neck of VA,

Serves 5 Rural Counties

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Project Connect Pilot Program

About:

2 Small Hospitals,

2 Free Health Clinics,

1 Community Health Clinic,

5 Very small Public Health Facilities,

No access to prenatal care for uninsured

Desired Outcomes

- Improve Client Access to Health Care
- Develop Policy/Protocol for Identifying and Improving Health Care for Clients/Residents
- Establish Plan for Cross Training and increased Collaboration between Shelter Staff and Health Care Providers and Institutions
- Compile and Develop Health Care Resources for Staff and Clients
- Develop a Plan for Sustainability
- Develop a Program that can be Replicated

Sustainability

Create a "Culture of Wellness"

- Changes must include clients and staff
- Become overall part of the Culture of the Agency

Focus on Prevention

Center around Health Promotion

- Fitness
- Healthy Eating
- Smoking Cessation
- Reproductive Health

Shift in Overall Philosophy of Shelter Program

- Trauma Informed
- Empowering/Participant Directed
- Healthy and Safe
- Culturally Relevant

Implementation

- Building Partnerships
- Training
- Policies and Procedures
- Environment

Partnerships

- Memorandums of Agreement with Health Care Provides/Public Health Agencies/ Mental Health Agencies
- Medical Reserve Corp – Volunteer Nurses
- Home Visiting Programs
- Pharmacies
- YMCA
- Food Bank and Local Growers/Farmers

Training

- Staff/ Board/ Volunteers
- Community Health Care Providers
- Volunteer Nurses
- Home Visiting Programs

Policies and Procedures

- Redo Entire Intake Process
- All Policies and Procedures Reviewed and Re-Written

Emphasis on Shelter Philosophy Services that are Trauma Informed, Empowering, Healthy and Safe and Culturally Relevant

Environment

- Created Sanctuary Room
- Availability of Fresh Fruit
- Removed signs
- Moved Smoking Area
- Created Recreation Space/Basketball Court
- Confidential Space for Nurse Visits/Interviews
- Information on Health Issues – Reproductive Health/Smoking Cessation/Healthy Diet
- Recycling
- Installed Water Coolers
- Reduced Overall Clutter

Results

- A Healthier / Happier Staff!
- Fewer Emergency Room Visits
- Enhanced/Expanded Community Partnerships
- Increase in # of Residents/Clients Connected to a Medical Home
- Increased Access to Reproductive Health Options for Staff and Residents
- Fewer “Shelter Crisis” Situations
- A Sustainable Cultural Shift in Agency

POLL #4

Anna Williams & Mercedes Hill

HAVEN
Serving Victims of Domestic Violence & Sexual Assault

Safe Futures Project

The Dalles, OR

FAMILY JUSTICE CENTER ALLIANCE

ABOUT HAVEN

HAVEN is a non-profit agency dedicated to supporting and empowering survivors of domestic and sexual violence. The organization began in 1981 with a very small group of concerned citizens. One of the first services HAVEN offered was a 24-hour crisis hotline, which still continues today.

MISSION: *To provide safe and supportive services to those affected by interpersonal and sexual violence by empowering survivors and our community through advocacy, education and prevention*

HAVEN SERVICES

- 24-hour Crisis-line
- Emergency Shelter
- Emergency Hospital response for survivors of Domestic and/or Sexual Assault
- Emergency Transportation
- Trauma informed counseling for domestic and sexual violence and/or stalking (adults, teens, children)
- Information and Referral to other agencies and/or social services
- Healthy Relationships Classes for survivors of Domestic Violence
- Support Group for Survivors Sexual Violence
- Legal/Court advocacy
- Bilingual/Bicultural advocacy
- Public Awareness Presentations and community training (English only)
- Violence Prevention Education
- Community Collaboration and Education
- Volunteer Training
- Health and Systems Advocacy
- Out-stationed advocacy at Public Health, One Community Health, DHS District 9 and Frontier Tri-County
- Professional training

A History of Community Collaboration

2002 → 2009

Out-stationed advocate at Department of Human Services (DHS), 2002 to present

•**Funding from various sources**

Community Mapping Project

•**1 in 3 families involved with DHS identified domestic violence as a family stressor.**

•**DHS identifies HAVEN's co-located advocate as one of the most efficient sources of support for child welfare cases**

A History of Community Collaboration

- Oregon IPV and Pregnancy Grant

More Info

- Project Connect funding

Project Connect
A Coordinated Public Health Initiative to Prevent Violence Against Women
Funded by the Office on Women's Health, US Dept of Health & Human Services

More Info

Safer Futures Project (SFP)

Partners:

- North Central Public Health District (NCPHD)
- One Community Health (a Federally Qualified Health Center)

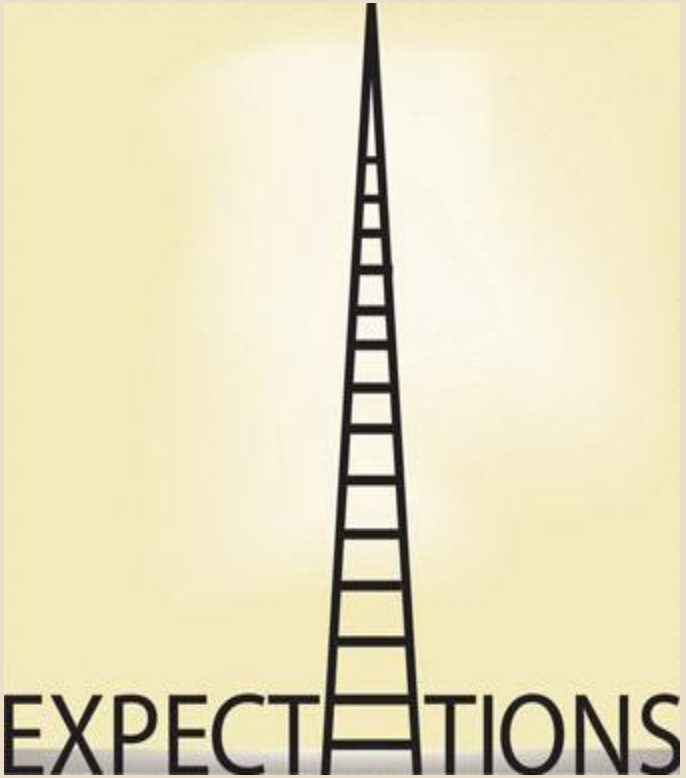
More Info

Approach:

- Team-based
- Accessibility is key
- Location – advocacy services are within walking distance from all community partners

Clarify Roles and Expectations
(and then do it again!)

- **Monthly meetings with Leadership** from all participating organizations to clarify roles and responsibilities
- **Monthly meetings for HAVEN team** to update and ensure consistency
- **Frequent and repetitive training** for partner staff
  - Project goals & expectations
  - Screening
  - Confidentiality & Communication
- **Frame collaboration** as an opportunity for clients to access resources

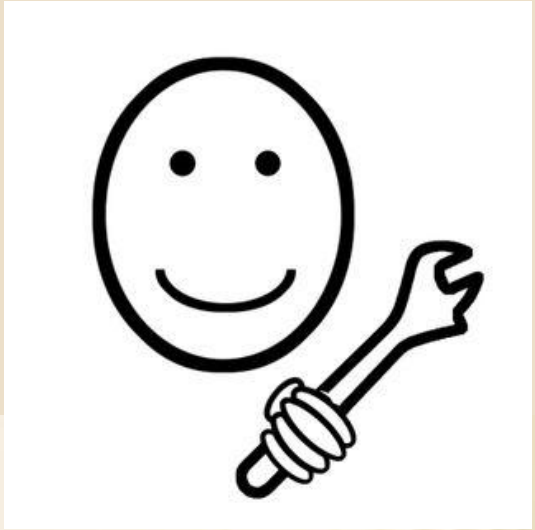


Watch & learn before you speak!

- Identify opportunities for informal connections within their work flow
- Quiet, observant, non-judgmental services from the start
- Don’t be afraid to get personal
- Ask questions
  - Direct service staff
  - Management if necessary

Make yourself useful

- Be there, offer support for whatever needed
  - Loading supplies, moving chairs, etc.
- Demonstrate to partners that you are there to be helpful



Take advantage of downtime

- Carpool to rural clinic sites
  - Use car time for informal conversations &training
  - Another opportunity to get personal
- Hang out in break rooms with outreach materials, training, tools
- When Public Health staff know your name, screening and referral is much more effective
  - Introductions are personal… “Mercedes is here today, she can come talk to you.”
  - Rather than “We have a community partner here…”

Train, train, and retrain

- Start the project with training – Project Overview & Goals
- Provide formal and informal training on techniques and protocols as often as possible
- Use their language as much as possible
- Walk your talk
- Ask partners what topics they'd like to cover in training
- Use your team!
  - At least 5 people from HAVEN have provided training on this project in the last year

Celebrate!

- Share success with partners
  - Statistics, reports, clients stories
- Share success with community
  - Events, radio & web coverage, newspaper
- Public acknowledgement of successful collaboration
  - Makes it worth it
  - Encourages additional investments
  - Changes community norms and breaks down silos
  - Ongoing quality improvement

POLL #5

Questions?

Contact Information:

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  vduplessis@futureswithoutviolence.org

- Ruth Micklem

  Tel: 804-333-1099

  cra@havenshelter.org

- Mercedes Hill

  Tel: 541-296-1662

  mercedes@haventhedalles.org

Join us next week!

Wednesday, February 26th

12 – 1:30pm PST

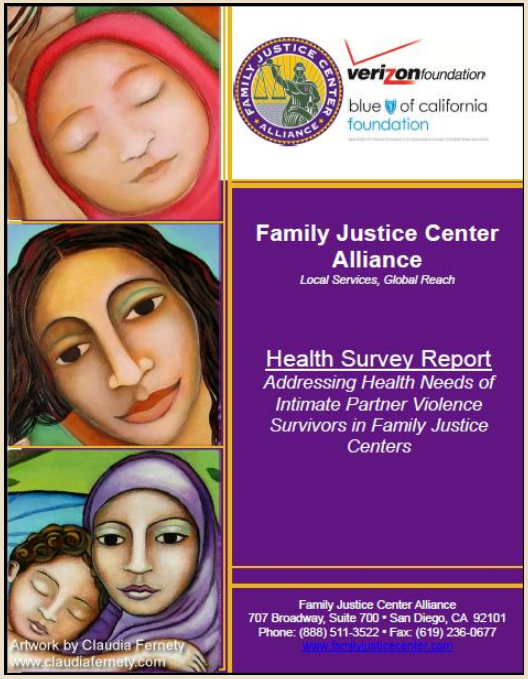
REGISTER

U-Visa Discoverability, What to Do?

Multidisciplinary Panel Discussion:

- Gail Pendleton, ASISTA
- Mike Agnew, Ret. Det. Fresno PD
- Wanda Lucibello, Brooklyn DA's Office
- Gael Strack, Alliance

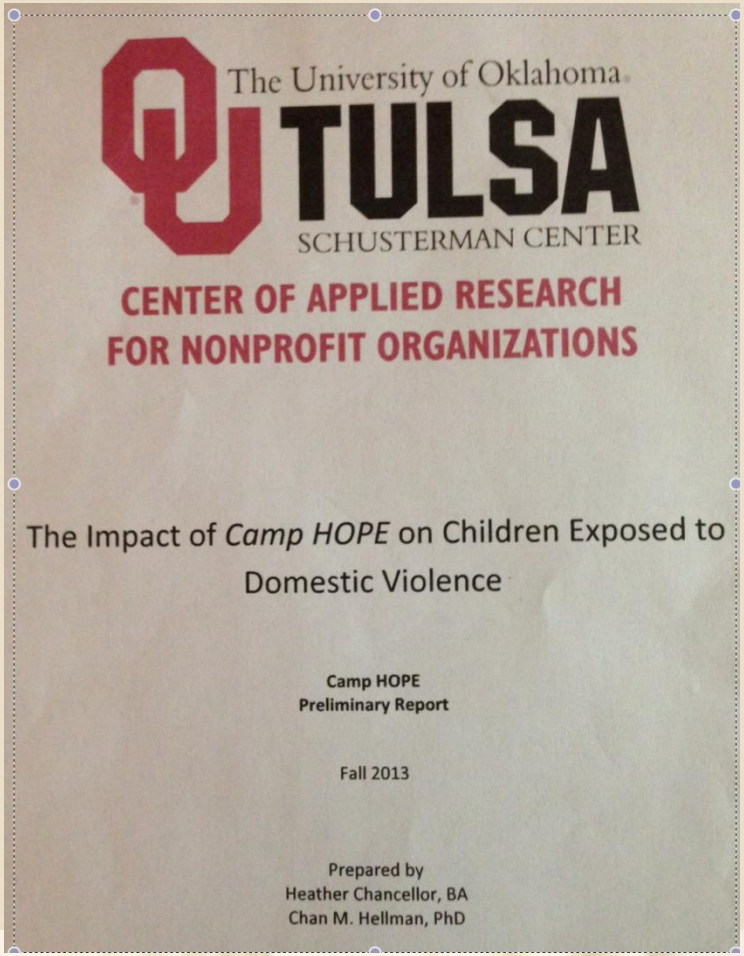
Health Survey Report



Released! Find it here!
Resource Library, under “Medical”.

Camping and Mentoring

- What will you do together besides intervention?
- What will your prevention strategy include?
- How can the Camp HOPE California model benefit your children receiving services after exposure to DV?
- OU- Tulsa Evaluation Report 2013 – Camping and Mentoring Produces HOPE in Children!
- HOPE Scale Pre-Post: 25.5 to 27.6


The University of Oklahoma
TULSA
SCHUSTERMAN CENTER
CENTER OF APPLIED RESEARCH FOR NONPROFIT ORGANIZATIONS

The Impact of *Camp HOPE* on Children Exposed to Domestic Violence

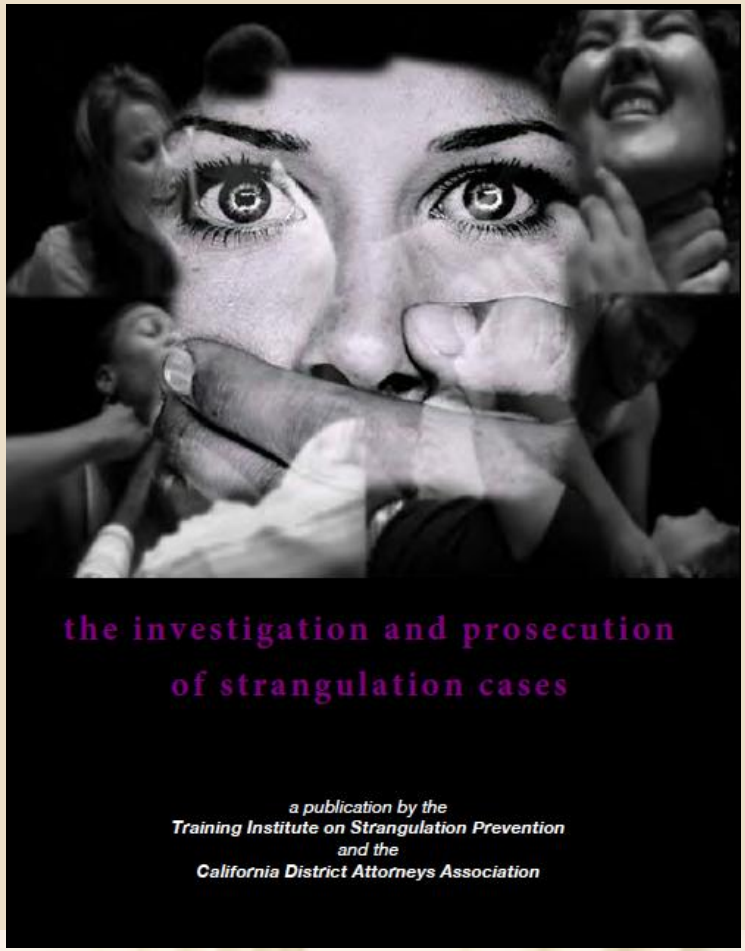
Camp HOPE
Preliminary Report

Fall 2013

Prepared by
Heather Chancellor, BA
Chan M. Hellman, PhD

Alliance Publishes New Manual!

- IPV Strangulation Crimes Manual – Developed by the National Family Justice Center Alliance/Training Institute on Strangulation Prevention
- In Partnership with the California District Attorneys Association
- Manual includes chapters on advocacy, investigations, prosecution, and legislation, among other topics

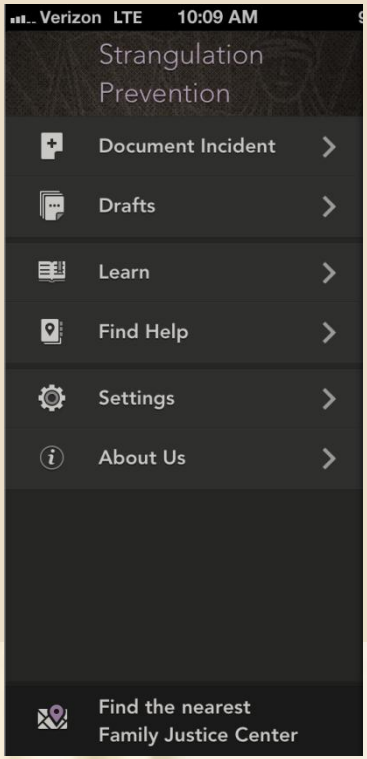


New iPhone APP

"Document It"

A Mobile App to Document Near-Fatal Strangulation Cases
The mobile application will assist professionals from ***all disciplines*** and individuals who are "choked" by an intimate partner to document multiple incidents using:

- Photo, Video, and Audio capture
- User-friendly survey of possible symptoms and injuries
- Text area to tell the story of the incident
- Signed consent for release of information; and
- Ability to send a full report to law enforcement
- Confidential storage



FAMILY JUSTICE CENTER ALLIANCE

2014 International Family Justice Conference – San Diego April 2-4, 2014

Join us at the San Diego Hilton Bayfront Hotel!
Go to www.familyjusticecenter.com to Register! **Early Bird End Feb 21**

FAMILY JUSTICE CENTER ALLIANCE

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This webinar presentation is being recorded and will be posted on our website by close of business

If you would like to access our new Resource Library, please visit our website at www.familyjusticecenter.com and click on **“Resources”** tab → **“Resource Library”.**

Thank You

Thank you for joining today's presentation

Family Justice Center Alliance
707 Broadway, Suite 700
San Diego, CA 92101
888-511-3522
www.familyjusticecenter.com

**Reminder: This presentation will be available for download on the Online Resource Library within 24 hours*

Anna Williams, MSW
Program Manager
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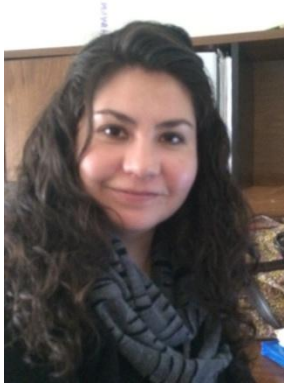
The Dalles, OR 97058
office: 541.296.1662

Biographical Information

Anna is HAVEN's Program Manager. As Program Manager, Ms. Williams supervises and empowers the advocacy and prevention staff at HAVEN . Ms. Williams manages specific projects for HAVEN, including the Safer Futures Project (SFP), Sanctuary, and the DHS Out-Stationed Contract. Her work on SFP includes development and training for the health care community and other relevant community partners. She assists with planning, staff development, clinical supervision, community partnerships, and team building. Anna is passionate about legislative and systems advocacy, strengths-based management, and enjoying life with the people she loves.



Mercedes Hill
SFP Project: Bilingual/Bi-cultural DV/SA Co-located Advocate

Biographical Information

Mercedes works directly with clients to provide information and support to them as they decide how to handle the violence in their lives. She spends many hours assisting clients as they navigate other social service agencies. Ms. Hill educates survivors, medical providers, social service providers, and the community on the dynamics of violence and appropriate community responses for IPV survivors Ms. Hill provides advocacy services to patients and clients at the following locations: DHS Child Welfare, DHS Self-Sufficiency, Public Health (locations in Wasco, Sherman, Gilliam & Wheeler counties). The co-located health advocate works closely with HAVEN's other co-located advocates who provide on-site services at DHS and in Wasco County, Hood River County, and the Frontier Tri-county.

Virginia Duplessis, MSW
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office: 415 678-5610
cell: 510 932-5283

Biographical Information

Virginia Duplessis is a Health Program Manager at Futures Without Violence, providing oversight and technical assistance for multiple national initiatives designed to improve the public health response to violence against women and increase the capacity of domestic violence services providers to address the health needs of their clients. She brings over 20 years of experience in the domestic violence, sexual assault, and public health fields. Ms. Duplessis has worked extensively with health care and social service providers, developing training and educational materials on a range of health and behavioral health. Trained as a social worker, she has also worked directly with community members, youth, and victims/survivors of violence as an advocate, counselor and prevention educator. Ms. Duplessis received her BA in Communications from Stanford University and her MSW from UC Berkeley.

Bio Ruth Micklem

Community Response Coordinator, The Haven Shelter and Services, Inc.
P.O. Box 1267
Warsaw, VA 22572
cra@havenshelter.org

Biographical Information

Ruth Micklem currently is employed with The Haven Shelter and Services, in Warsaw, VA, as the Community Response Coordinator, where she works in 5 rural counties to coordinate the Community Response to Sexual and Domestic Violence. Prior to returning to work at the local level, Ruth served as one of three co-directors of the Virginia Sexual and Domestic Violence Action Alliance (VSDVAA). As Co-Director of Virginia's sexual and domestic violence coalition Ruth's primary responsibilities include; monitoring public policy and addressing the public policy needs of battered women, survivors of sexual violence and domestic and sexual violence programs; and providing support and direction to a team of staff who provides training and technical assistance to local sexual and domestic violence programs throughout the Commonwealth, operates the Statewide Family Violence and Sexual Assault Hotline, operates a statewide Training Institute, manages VAdata, the statewide data collection system for local domestic and sexual violence programs and manages a statewide resource library.

During her 19 year tenure at VSDVAA Ruth has served as a member of Attorney Generals Mary Sue Terry's and Jerry Kilgore's Task Forces on Domestic Violence, and served as a member of the VA Commission on Family Violence Prevention. She has represented the Coalition on a number of legislative studies and commissions, including the Gender Bias Task Force of the Supreme Court of Virginia and the Office of the Chief Medical Examiner's Advisory Council for the development of Model Intimate Partner Violence Fatality Review Protocols, and the Governor Tim Kaine's Commission on Sexual Violence. Ruth was also appointed by Governor Mark Warner to the State Council for Adult Offender Supervision. Ruth currently serves as a member of the Chief Justices Domestic Violence Advisory Committee of the Supreme Court and as a member of the Statewide Maternal Mortality Review Team in the Office of the Chief Medical Examiner.

Prior to her position at VSDVAA, Ruth has worked in local domestic and sexual violence programs in Williamsburg, VA Beach/Norfolk and Petersburg, VA.

Sara Wee, MPH
Public Health Program Associate
National Family Justice Center Alliance
619-573-4345
sara@nfjca.org

Biographical Information

Sara is the Public Health Program Associate for the Alliance, where she leads project initiatives for the Health Initiative, which aims to develop program models to integrate health services into Family Justice Centers. She is currently providing technical assistance at a pilot site, Valley CARES FJC, to expand their SART model into broader health services, and evaluate the results to later build tools and resources to other FJCs as they seek to integrate and/or co-locate health services.

B.A. (Before the Alliance) Sara started her work in the movement to end violence in the primary prevention field. She was the Coordinator for a Violence Prevention Program in the Lake Tahoe region of California/Nevada, where she developed curriculum, led community outreach, and created a Teen Advocacy Program.

Sara received her Masters in Public Health from Columbia University in New York City with a focus in health promotion and program development. She continued her work in youth outreach by working as a Youth Advisor for the Lang Youth Program, dedicated to training youth from underserved communities (Washington Heights) in the health-sciences and increasing their access to higher education. Sara also worked with the NYC Mayor's Office to Combat Domestic Violence (OCDV), which works to coordinate City and community services for domestic violence, establish City policies to protect victims and their families, and conduct community education around issues of violence. OCDV also supports the development and operations of 4 open FJCs (Bronx, Queens, Brooklyn, Manhattan), and 1 developing site in Staten Island. Sara's work with OCDV focused on addressing a high-incidence of family-related homicides in Brooklyn by leading a community needs assessment with service providers, survivors, and community members. She worked with OCDV staff to establish work priorities for OCDV , recommendations for City Agencies, and propose program components for the Brooklyn FJC, which were published in OCDV's Annual 2012 Report.

Today, Sara continues to work as a teaching assistant at Columbia University and is working on publishing research on a study of bystander behavior in collaboration with Dr. Victoria Frye, a violence prevention and HIV-prevention expert.

Missed Opportunities: Emergency Department Visits by Police-Identified Victims of Intimate Partner Violence

Catherine L. Kothari, MA
Karin V. Rhodes, MD, MS

From the Borgess Medical Center, Kalamazoo, MI, and the Department of Emergency Medicine, Michigan State University/Kalamazoo Center for Medical Studies (Kothari); and the Section of Emergency Medicine, University of Chicago, Chicago, IL (Rhodes).

Study objective: We examine all emergency department (ED) utilization by police-identified women victims of intimate partner violence as part of an intimate partner violence ED surveillance study to determine the frequency and characteristics of visits and the extent of intimate partner violence screening and identification by ED staff.

Methods: We conducted a retrospective observational case series reviewing countywide EDs visits, 1999 to 2001, for women victims in the 2000 prosecutor's intimate partner violence database. Stratifying visits by whether the woman presented with an injury, we assessed documentation of intimate partner violence screening and identification and mental health and substance abuse in the medical records.

Results: Of 964 female intimate partner violence victims in the 2000 prosecutor's intimate partner violence database, 616 (63.9 %) received care in at least 1 ED in the year of the index assault. During the 3-year study period, 788 (81.7%) victims generated a total of 4,456 ED visits. Intimate partner violence screening was documented in 1,349 (30.3%) of the 4,456 visits but resulted in only 259 (5.8%) positive screens. However, because they use the ED so frequently, 23.0% of individual intimate partner violence victims were eventually identified. The median number of visits for victim ED users was 4 (range 1 to 71), and visits were just as likely to occur before the known intimate partner violence incident as after, although ED visits tended to peak in the month of the incident. Injury-related visits were 50% more likely to have documented IPV screening, however, most visits (71.2%) by IPV victims were for noninjury-related complaints.

Conclusion: Police-identified intimate partner violence victims utilize emergency care at extremely high rates, usually without identification or referral to intimate partner violence resources. [Ann Emerg Med. 2006;47:190-199.]

0196-0644/$-see front matter

doi:10.1016/j.annemergmed.2005.10.1016

SEE EDITORIAL, P. 200.

INTRODUCTION

Background and Importance

Although the literature has an abundance of information about the long-term adverse health sequela and prevalence of intimate partner violence among female patients,[1–3] much less is known about health care use by known victims of intimate partner violence. Likewise, whereas information on fatal and hospitalized injuries is fairly complete, data on patients who visit hospital emergency departments (EDs) are more limited. In an effort to close this information gap, the Michigan Department of Community Health established the Michigan Intimate Partner Violence Surveillance System, which linked intimate partner violence cases from the prosecutor database to ED visits. This study found that only 5.8% of female victims of intimate partner violence assaults were treated in the ED for the assault that prompted the police request for arrest of the perpetrator.[4] This finding raised questions about the exact nature of ED utilization by victims of intimate partner violence who are involved with the criminal justice system and the frequency of missed opportunities for identification of these victims of violence. Given that intimate partner violence is, by definition, a pattern of abuse taking place over time and results in ongoing adverse health sequela, we expected high ED utilization for both medical and injury-related complaints. Although it is well known that ED providers are poor at universal screening, we expected that intimate partner violence

Editor's Capsule Summary

What is already known on this topic

Victims of intimate partner violence often pass through the emergency department (ED) undetected.

What question this study addressed

This study investigates how often victims of intimate partner violence, as identified from police records, used the ED and how often they were identified as victims.

What this study adds to our knowledge

Of 964 intimate partner violence victims identified by the county prosecutor's office, 64% had at least 1 ED visit during the year of the index assault. ED staff identified the existence of intimate partner violence in only 6% of these visits. The greatest number of ED visits occurred during the month of the assault. In 28% of visits, the chief complaint was an injury. Less than 30% of visits had documentation of intimate partner violence status regardless of chief complaint.

How this might change clinical practice

These data suggest that physicians need to screen more frequently for intimate partner violence and document their screening, particularly in women with injuries.

screening and identification would be more likely if the woman were presenting for an injury-related complaint. From the perspective of reducing victimization, if we can improve our understanding of the manner in which occult intimate partner violence victims present for emergency care, it may increase ED identification and referral to intimate partner violence services before police involvement.

Goals of This Investigation

The goals of the current study were to broadly characterize type and frequency of all ED utilization by police-identified female victims of intimate partner violence assault in 2000 and to determine the extent of intimate partner violence screening and identification by ED staff.

MATERIALS AND METHODS

Study Design

We conducted a retrospective observational case series of countywide ED utilization by a known population of women identified as victims in the county prosecutor's intimate partner violence database. To track ED utilization over time, capturing patterns of increasing and decreasing usage, we decided on a 3-year study period. At study initiation (Fall 2002), the most current 3-year period was 1999 to 2001, making 2000 the year of the index assault, 1999 the year before the index assault, and 2001 the year after the index assault. For female victims with more than 1 intimate partner violence assault in 2000, the first recorded assault was selected as the index case. ED data were collected through electronic medical record review.

Setting

We used data from 1 county in southwest Michigan, containing 2 midsized cities and several rural communities, with a total population of 238,603, making it the eighth largest county in the state.[5] Of the total population, 98,173 are adult women aged 16 and older. These adult women are predominately white (88.4% white, 8.2% black, 1.9% Asian, and 0.5% American Indian), and half (50.6%) are married.[6,7]

The county is served by 2 Level I trauma centers and 6 tertiary care EDs under the umbrella of 2 private community hospital systems, for a total of 8 EDs. Both hospital systems follow state law and Joint Commission on Accreditation of Healthcare Organizations guidelines for domestic violence screening and intervention. They both have academic affiliations with a local medical school; emergency and family medicine residents rotate through the 2 trauma centers. Michigan law requires that all violent injuries treated by a medical facility be reported to a law enforcement agency, but there are no reporting laws specific to intimate partner violence. Hospitals protocols require screening for violence on every ED intake form (completed by triage nurses) and reporting of any assault-related injury to a police agency and, if indicated, safety planning and referral to community victim service agencies.

Criminal justice policies for intimate partner violence reflect state law and include (1) proarrest policies (mandated arrest if responding officer finds probable cause for assault), (2) evidence-based, "victimless" prosecution (aggressive collection of all available evidence to supplement victim testimony and the pressing of charges by the prosecutor, not the victim), (3) court-based victim advocates who solicit victim input and help link victims to community services, and (4) sentencing guidelines that include Batterers' Treatment Program participation for convicted intimate partner violence perpetrators. These policies have developed under the guidance of a coordinated community response to intimate partner violence.[8]

Selection of Participants

In 2000, of the 98,173 adult women in the county,[9] 964 (≈1%) were victims in 1,094 intimate partner violence assault cases identified by the county prosecutor's office. The term "case" will be used to describe incidents of assault that have reached the level of a crime within the criminal justice system, with an arrest warrant issued. A single case may result in multiple charges (such as assault and robbery). In Michigan, the highest-order assault cases, homicide and criminal sexual conduct, are not specifically tagged as intimate partner violence within the prosecutor's records and thus could not be identified for inclusion in the study population. Inclusion criteria were cases in 2000 that included at least 1 charge of an intimate partner violence assault, as identified by the charge codes (Michigan statutes 750/812, 750/813, 750/814, 750/81A, 750/81A3), with a documented intimate partner relationship (spouse

or former spouse, current or past dating partners, or having a child in common) between the parties. We excluded cases in which the victim or defendant was a minor (defined as younger than 16 years) or the victim was male.

The prosecutor database contained intimate partner violence victim identifiers (full name, date of birth, address) and case descriptors (cases requested, cases approved by prosecutor's office, misdemeanor or felony, disposition, injury noted by law enforcement, and victim-defendant relationship). Access and permission to use the prosecutor administrative records database were granted by Kalamazoo County Prosecuting Attorney's Office and facilitated by the Michigan Department of Community Health. Because this was a public health surveillance study, a waiver of consent for medical record review was granted by the institutional review boards of the 2 participating hospital systems.

Data Collection and Processing

We developed a structured abstraction form and coding scheme after reviewing 10 medical records known to contain extensive intimate partner violence documentation. We further refined the form and codes after abstracting the first 50 visits. During the study, 11 research assistants (2 registered nurses, 2 graduate students, 4 undergraduate students, and 3 high school seniors) reviewed the electronic medical records of the 2 hospital systems and then abstracted and entered data for all ED visits. Research assistants received a 2-hour training session, supplemented by a training manual with instructions and examples, for review, abstraction, coding, and data entry of medical records. After initial training, assistants entered a probationary period for their first 100 charts, wherein 100% of their work was reviewed by the project manager. After this probationary period, all questionable codes were reviewed by the project manager and discussed until consensus between the research assistant and project manager was achieved. Research assistants had reviewed the study protocol and were aware of study goals.

Reviews included emergency medical service assessment forms, visit intake and discharge forms, physician dictations, nursing notes, injury body map forms, photographs, and violent injury report forms. Medical records for both hospital systems are maintained and available for review electronically; forms, nursing notes, and photographs are scanned in, whereas dictations are transcribed directly into the medical records systems.

Cases were matched in 2 phases within each of the 2 hospital medical records systems. First, a search of the medical records was conducted by name (last name, first name). Matches were then confirmed through date of birth or, in the few cases in which there was a missing date of birth in the prosecutor records, an address. Because our study population was female and thus subject to name changes with marital changes, a second phase of record matching was conducted within each medical records system for the unmatched cases. In the second phase, medical records were searched by date of birth, followed by first name. Often, records identified this way contained previous last name within the text of a form, and we were able to confirm matching. If not, confirmation was through address matches. Questionable matches, those not meeting the above criteria, were considered unmatched and, thus, not considered ED users.

Once a victim was confirmed as an ED user, we abstracted all ED visits during the 1999 to 2001 study period. For each visit, we collected demographics (age, race, marital status, insurance status), date and time of visit, site of visit, reasons for visit (chief complaint and secondary complaints recorded on the intake form), discharge diagnoses (listed verbatim in the physician dictations), and documented intimate partner violence screening and identification by ED staff. Intimate partner violence screening was defined as any mention in the medical record of intimate partner violence through marking either the yes/no boxes for the screening question on the visit intake form or through documentation of screening and patient responses by staff. Our definition of screening included all negative screen results, as well as cases in which intimate partner violence was documented. Intimate partner violence identification was defined as marking the yes box for the screening question on the intake form or documentation of patient disclosure or staff suspicion of recent or past physical or sexual assault by an intimate partner. For intimate partner violence screening and identification, the individual staff responsible for that documentation was coded (as triage nurse, treatment nurse, or physician) and recorded. We also coded whether or not the visit was injury related. A visit was considered injury related if injury was noted either as one of the reason-for-visit complaints or one of the discharge diagnoses. Finally, we coded whether or not the visit included documentation of mental health or substance abuse comorbidities. Although conceptually a history of mental health or substance abuse could be considered an individual-level variable, we found that this documentation varied visit to visit, so we defined it as a visit-level variable. Specifically, a visit was coded as having a mental health comorbidity if the reason-for-visit complaints, discharge diagnoses, or any staff notes or dictations included suicidality or a mental health issue (ie, depression, anxiety) either past or present. Similarly, a visit was coded as having substance abuse comorbidity if these same records included a substance abuse issue (ie, overdose, alcohol intoxication, or suspected drug-seeking by staff) either past or present. This definition of substance abuse captures authentic substance abuse (drug overdose, for example) and perceived substance abuse (suspected drug-seeking noted by staff).

To assess interrater reliability, we randomly selected 10% of the sample and double abstracted and data entered all visits from this subsample. Using the κ statistic, we found that there was 89.7% agreement about documentation of intimate partner violence. All discrepancies were then reviewed by the project manager, discussed with research assistants, and resolved by consensus. Although prosecutor records provided complete and

consistent case-related variables, the quality of victim demographics was not as good because the primary criminal justice focus is on the defendant and the case itself, rather than the victim. So, where possible, demographic variables were derived from medical records. There were only 46 (4.8%) victims of the sample that had no medical records at all in either hospital system; for this group, we relied on prosecutor records.

Primary Data Analysis

For analysis, we created 2 files from the collected data: an individual-level file, in which the unit of analysis was the victim and the number of records equaled the sample size of 964, and a visit-level file, in which the unit of analysis was the ED visit and the number of records was all visits by all ED users. Individuals were assigned a unique identification number that was used to link information across datasets.

The individual-level file was constructed from abstracted medical records and case descriptors present in the SPSS (version 12; SPSS, Inc., Chicago, IL) data sample file provided by the prosecutor's office. We used this file to characterize the study population on demographics (age, race, marital status), number of known assault cases in the index year 2000, disposition of the index assault case, injury and medical treatment information, and ED utilization (ED user or not, number of visits, location of visits). The visit-level file was based on abstracted medical records and was used to profile all ED visits by the sample on the following: injury related, documentation of mental health or substance use or abuse, documented screening for intimate partner violence by provider type (triage nurse, treatment nurse, physician), and identification of intimate partner violence by provider type. Date of index event was merged into the visit-level file to identify ED visits as occurring after or before the intimate partner violence index event.

The data were entered and analyzed using SPSS version 12.0. Descriptive statistics were calculated for all variables in both analytic files. Additionally, data were stratified and frequencies calculated by whether or not the victim used the ED and whether or not the visit was injury related. Given that these data are nonparametric, numeric variables, "number of visits," and "number of months before/after event" are summarized by median and range.

RESULTS

Table 1 presents demographic and case descriptors for the 964 individual women who were police-identified victims of intimate partner violence in 2000. Intimate partner violence victims tend to be in their childbearing years (61.7%; n=595 are aged between 20 and 34 years), and disproportionately black (36.9%; n=356 is 4.5 times the county black population of 8.2%). Most (81.9%; n=790) were in a current, usually a dating, relationship.

During the index study year 2000, the majority (89.1%; n=859) of the police-identified victim population had been involved in only 1 case. These are cases in which a law enforcement agency has responded to an assault call and subsequently submitted a case request form to the prosecutor's office, which would allow arrest of the suspected perpetrator. Considering only the index assault cases (the first one in 2000, for those with multiple assaults), nearly 80% (n=757) of case requests result in approval, which means the suspected perpetrator can be arrested and charged with a crime. More than two thirds (n=520) of the approved cases resulted in conviction, either through plea bargaining or trial, and more than 60% of cases (n=576) involved some form of physical injury, mostly minor, as observed and noted by the responding officer (n=550).

When intimate partner violence victims who used the ED care are compared to those who did not, ED users are younger and more likely to be black. Assault by a former boyfriend is more likely among ED users than nonusers, whereas assault by a current spouse is more common among non-ED users. The figures in Table 1 describing the criminal justice case show that ED users are more likely to have multiple cases and to have visible injury noted by police.

Nearly two thirds (63.9%; n=616) of intimate partner violence victims involved with the criminal justice system used an ED in 2000, the year of the index assault case. Figure 1 shows that, during the full study period, 1999 to 2001, the proportion of victims with at least 1 ED visit increased to 81.7% (n=788). These 788 ED users generated a total of 4,456 ED visits, with a median of 4 visits each. Furthermore, among the ED users with more than 1 visit during the study period (n=655), more than half (58.6%; n=462) appear to be hospital hopping, visiting multiple EDs.

Figure 2 illustrates the pattern of ED visits relative to the index intimate partner violence event. Spanning the entire study period, 48.6% (n=2168) visits occurred before the index event, and 51.3% (n=2288) of visits occurred after the index event. The distribution of visits is symmetrical before and after the index event, with the greatest number occurring the month of the event.

Injury-related ED visits account for 27.5% (n=1225) of all visits by the victim population. For the bulk of injury-related visits, there is no documentation that the mechanism of injury is assault (n=817). Where there is documentation of assault (n=408), most (5.8% of total visits; n=259) patients note that the assault was committed by an intimate partner. But overall, non–injury-related visits far outnumber injury-related visits; 71.2% (n=3,172) of all ED visits compared with 27.5% (n=1,225). Presentation for injury complaints does not vary by whether the visit occurs before or after the intimate partner violence event, except for ED visits in which intimate partner violence is identified or known. Most (70.6% "before" and 73.6% "after") ED visitors present with noninjury complaints. However, among the 259 intimate partner violence–known visits, more of these occurred before the index police-identified

Table 1. Demographics and case cescriptors -total and stratified by ED usage.

Demographics	Total (N = 964)	ED Usage: Used ED (N = 788)	ED Usage: Did NOT Use ED (N = 176)
Age *(%, n)*			
16–19	8.2 (79)	8.5 (67)	6.8 (12)
20–24	24.7 (238)	26.6 (210)	15.9 (28)
25–34	37.0 (357)	37.6 (296)	34.7 (61)
35–44	21.5 (207)	19.7 (155)	29.5 (52)
45–54	7.3 (70)	7.1 (56)	8.0 (14)
55+	0.7 (7)	0.5 (4)	1.7 (3)
Missing	0.6 (6)		3.4 (6)
Race *(%, n)*			
White	57.2 (551)	56.6 (446)	59.7 (105)
African American	36.9 (356)	39.0 (307)	27.8 (49)
Hispanic	2.9 (28)	2.9 (23)	2.8 (5)
Asian	0.3 (3)	0.4 (3)	0
Missing	2.7 (26)	1.1 (9)	9.7 (17)
Relationships *(%, n)*			
Current Spouse	30.4 (293)	28.8 (227)	37.5 (66)
Current Girlfriend/Boyfriend	51.6 (497)	52.3 (412)	48.3 (85)
Homosexual	0.1 (1)	0.1 (1)	0
Former Spouse	1.3 (13)	1.1 (9)	2.3 (4)
Former Girlfriend/Boyfriend	16.6 (160)	17.6 (139)	11.9 (21)

Criminal Justice Case Descriptors	Total (N = 964)	ED Usage: Used ED (N = 788)	ED Usage: Did NOT Use ED (N = 176)
# of Cases in 2000 *(%, n)*			
1	89.1 (859)	87.3 (688)	97.2 (171)
2	8.6 (83)	10.0 (79)	2.3 (4)
3	2.0 (19)	2.3 (18)	0.6 (1)
4	0.3 (3)	0.4 (3)	0
Disposition of Case Request* *(%, n)*			
Case Denied by Prosecutor	21.5 (207)	21.2 (167)	22.7 (40)
Case Approved by Prosecutor	78.5 (757)	64.4 (621)	77.2 (136)
Disposition of Approved Cases* *(%, n)*	*(n = 757)*	*(n = 621)*	*(n = 136)*
Conviction	68.7 (520)	68.4 (425)	69.9 (95)
Found Not Guilty	3.0 (23)	3.1 (19)	2.9 (4)
Dismissed	17.0 (129)	17.1 (106)	16.9 (23)
Open Case	11.2 (85)	11.4 (71)	10.3 (14)
Injury Recorded By Police *(%, n)*			
No Injury	37.7 (349)	36.4 (275)	43.8 (74)
Apparent Minor Injury	59.5 (550)	60.4 (457)	55.0 (93)
Major Injury	2.8 (26)	3.2 (24)	1.2 (2)
Missing (not included in %)	(39)	(32)	(7)
Transportation to Hospital Recorded By Police *(%, n)*	5.5 (53)	6.7 (53)	N/A

*For index case (the first case in 2000 for those with multiple cases)

event (57.5% of the 259 intimate partner violence ED visits) than occurred after (42.6%).

Table 2 shows that, overall, 21.7% (n=966) of ED visits include some documentation of a mental health or substance abuse comorbidity, either as the reason for the visit, noted in the patient history dictation, confirmed through results for blood drawn for laboratory tests for that visit or documented by physician as "suspected drug-seeking." Documentation of a mental health comorbidity and a substance abuse comorbidity is equally common. Stratification by type of injury-related visit

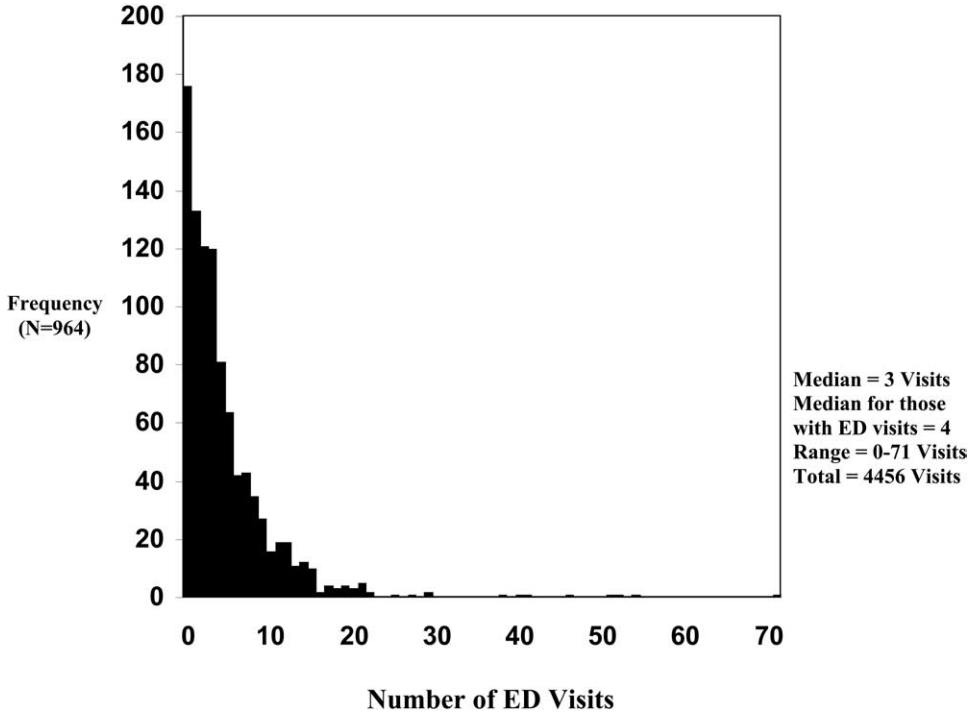

Figure 1. ED utilization. Total visits during the 3-year study period (N=964 individuals).

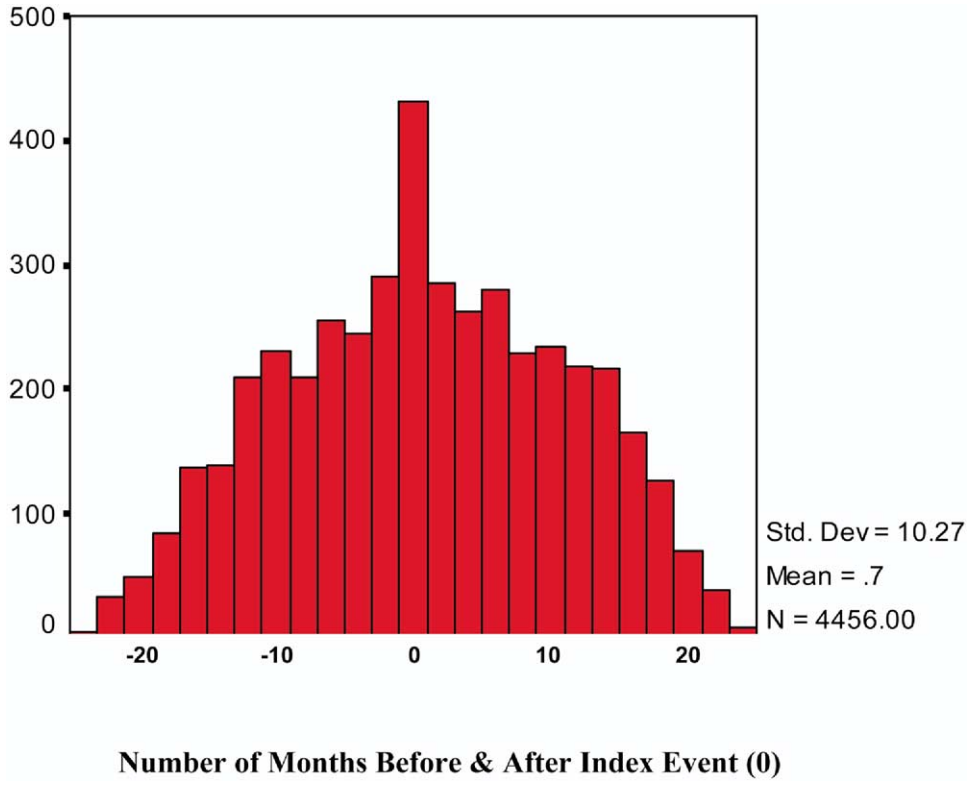

Figure 2. ED utilization relative to index intimate partner violence event. Number of ED visits in months before and after index event (N=4,456 visits).

Table 2. Percent of visits with mental health/substance abuse co-morbidities documented; total and stratified by injury.

		Type of Visit (N = 4456)			
	% of Visits* (N = 4456 visits)	Non-Injury Visit (n = 3172)	Injury, No Documented Assault (n = 817)	Injury, Known Assault (n = 149)	Injury, Known IPV Assault (n = 259)
Mental Health Issue Noted	13.5% (601)	14.2% (452)	8.3% (68)	17.4% (26)	20.1% (52)
Substance Abuse Issue Noted	13.3% (593)	12.0% (380)	11.5% (94)	30.9% (46)	28.2% (73)
Both Mental Health & Substance Abuse Issue	4.7% (209)	4.8% (151)	2.4% (20)	12.1% (18)	7.7% (20)
Either Mental Health or Substance Abuse Noted	21.7% (966)	21.2% (672)	17.3% (141)	34.2% (51)	38.2% (99)

*ED visits by the police-identified victim population

Table 3. IPV screening documentation; total and stratified by injury.

		Type of Visit (N = 4556)			
	% of ED Visits* (N = 4456 visits)	Non-Injury Visit (n = 3172)	Injury, No Documented Assault (n = 817)	Injury, Known Assault (n = 149)	Injury, Known IPV Assault (n = 259)
Triage Documents Screening	27.5% (1226)	25.9% (823)	25.1% (205)	25.5% (38)	61.8% (160)
Treatment Nurse Documents Screening	2.7% (121)	0.1% (3)	0.4% (3)	1.3% (2)	43.6% (113)
Physician Documents Screening	5.5% (244)	0.5% (17)	1.0% (8)	2.7% (4)	83.0% (215)
Anyone Documents Screening	30.3% (1349)	26.4% (838)	25.9% (212)	26.8% (40)	100.0% (259)

*ED visits by the police-identified victim population

demonstrates the variability of these comorbidities depending on the presenting reason for visit. An assault-related injury, whether intimate partner violence or not, nearly doubles the likelihood that a visit will include documentation of 1 or both of these comorbidities.

Table 3 details the intimate partner violence screening and identification documented in the medical records. A lack of documentation is the norm, characterizing 69.7% (n=3,107) of visits by police-identified intimate partner violence victims. This documentation is completed primarily by the triage nurse on the intake form. The rate of screening does vary by injury presentation; an injury-related visit is 50% more likely to contain documentation of intimate partner violence screening or identification than a visit that is a non–injury-related visit. Increased intimate partner violence screening and identification documentation is seen across staff positions, but the most notable increase is physician documentation. Of the 259 visits in which intimate partner violence has been identified, physicians are most likely to document the intimate partner violence (83.0%; n=215), followed by triage nurses (61.8%; n=160) and, finally, treatment nurses (43.6%; n=113). Physicians and treatment nurses rarely document negative intimate partner violence screens (0.7%, n=31; and 0.2%, n=9 of all visits, respectively), whereas triage nurses have the highest rate of documented negative screen results (24.2%; n=1,078 of all visits).

Only 5.8% (n=259 of 4,456 visits) of visits contained any documentation of intimate partner violence identification. However, when intimate partner violence identification is considered in terms of the individuals making these visits, 23.0% (181 of 788 ED users) of patients were eventually identified as intimate partner violence positive during at least 1 of their ED visits throughout the study period. The chance of being screened or identified with intimate partner violence increases with increased visits. The 298 ED users without any documentation of either screening or intimate partner violence identification at any of their visits had fewer visits overall (median 2 ED visits; range 1 to 29), whereas the 490 ED users with intimate partner violence screening or identification in at least 1 visit had more than double the number of visits (median 5 ED visits; range 1 to 71).

LIMITATIONS

This analysis is limited to 1 semirural county in the Midwest; determining the generalizability of our findings will require replication. Health care use data were limited to the ED setting and do not provide any information about the visit rates in other health care settings. Because our intimate partner violence sample was derived from the prosecutor's database, we are dealing with a specific group of intimate partner violence victims: those seeking help and relief through the criminal justice system. So our study does not address ED utilization by intimate partner violence victims who are not involved in the criminal justice setting. Furthermore, the criminal justice cases identified for the study did not include the most serious assaults, homicide and criminal sexual conduct. Because we did not have

income data for our sample, we were not able to account for income as a potentially confounding factor for ED usage. Additional study limitations include all the factors that are associated with retrospective studies reliant on documentation of behavior rather than actual behavior, which is particularly true of substance abuse documentation, which can be strongly influenced by provider bias. Nonetheless, most of the limitations associated with retrospective studies would be likely to result in underestimations, rather than overestimations, of the actual health care use.

DISCUSSION

This study adds to the literature on health care use by intimate partner violence victims by documenting extensive ED utilization by a population of intimate partner violence victims who were also seeking relief in the criminal justice system. The peaking of ED visits in the month surrounding the known intimate partner violence assault highlights the often hidden relevance of intimate partner violence to ED visits.

The majority of victims utilized ED services multiple times without ever being identified or linked to community-based or legal intimate partner violence resources, even when they presented with injuries. Screening, as currently practiced, seems unlikely to reliably identify intimate partner violence, unless the victim self-identifies or is transported to the ED by the police after an assault. Although this study focuses on police-identified intimate partner violence, population-based studies of intimate partner violence crime indicate that the majority of intimate partner violence victims do not call the police, and they are also likely to be using the ED.[10]

A number of evidence-based evaluations of screening for intimate partner violence in health care settings have been unable to make a recommendation either for or against routine screening for intimate partner violence.[11–13] Given the state of current intimate partner violence screening programs, we cannot yet conclude that a strong ED screening or intervention would be ineffective in decreasing morbidity and mortality, because we have yet to test such a program. Nor can ED providers avoid this responsibility or hide behind the lack of evidence for effectiveness, given the abundance of data about the impact of intimate partner violence on patients. Indeed, strongly suggestive causal links between experiences with abuse and future negative physical and emotional health outcomes[1,2,14] create the imperative for continued research about strategies for intimate partner violence prevention and harm reduction. Although other studies have documented excess health care use and costs related to intimate partner violence in primary care[15–17] and health maintenance organization settings,[14,18] they have relied on patient disclosure on surveys and have not had information about intimate partner violence victims that they might be missing in their utilization review. Our data allow a unique "postmortem" of ED service utilization and intimate partner violence screening outcomes by a population of known intimate partner violence victims. As such, we hope that careful examination of what we are missing will help us improve the care we offer.

In 2000, 64% of 964 female victims in police-identified cases of intimate partner violence in 1 county were treated at least once in an ED. This rate was 3 times the annual 21% rate of ED use by a population-based sample of women in the same age category.[19] For detecting acute abuse, it would seem that injuries would be the most important predictor. However, the majority (72%) of intimate partner violence victims presented for non–injury-related complaints. Other studies have found nonbattering presentations to be the rule rather than the exception[20] and increased utilization by intimate partner violence victims to be the result of negative physical and emotional health consequences of abuse experiences.[21–24] Unfortunately, in our study even when intimate partner violence victims presented with assault-related injuries, they were infrequently asked about abuse.

Given that both hospital systems in this study have procedures for intimate partner violence screening and intervention and intimate partner violence screening is included in annual in-service training of ED staff, it is informative to examine their intimate partner violence–related screening behavior. In a retrospective study, this behavior is apparent only through documentation within medical records. Often, whether intimate partner violence identification was the result of patient self-identification or active screening by ED staff cannot be determined. ED studies have reported intimate partner violence prevalence rates from 25% to 35%[24,25] using dedicated screeners, but most authors acknowledge that detection rates decrease dramatically when screening is left to busy ED staff.[26–28] Studies of barriers to the identification of battered women fault provider time constraints and reluctance to initiate discussions about partner violence.[29–32] Nonetheless, patients expect physicians to inquire and will usually disclose abuse if directly questioned.[33]

In our study, ED physicians almost never documented intimate partner violence status unless it was positive, but they were relatively good at following up on positive screen results identified by the nurses, which supports that a health care system that develops reliable routine screening for intimate partner violence will be able to focus the physician's attention on identified patients. Although only 5.8% of 4,456 visits by intimate partner violence victims included documentation of intimate partner violence, because victims presented so many times, 23.0% of 788 ED users were eventually identified as intimate partner violence victims during at least 1 ED visit. And many of the intimate partner violence disclosures (57.5%; n=134) occurred before criminal justice notification of an assault, which suggests that even systems with imperfect mechanisms for routine screening have multiple opportunities to identify high-risk victims and to identify them before assaults, at least those leading to 911 calls, occur.

The intimate partner violence victims were likely to have medical record documentation of substance abuse and mental health issues, which seemed to be a function of the fact that intimate partner violence–identified assaults were more likely to

be accompanied by mental health or substance abuse documentation than other injury-related visits, even for the same patients. Other studies have documented very high rates of co-occurring mental health and substance abuse problems in victims of intimate partner violence.[1,3,34,35] In our study, it is unclear whether increased documentation is a result of patient intimate partner violence disclosure during periods of crisis (eg, suicidal gestures, intoxication) or from provider intimate partner violence probing or bias. However, it is clear that it would be appropriate for ED providers to have a higher index of suspicion and get social workers involved when women are "frequent fliers" or present with mental health or substance abuse problems, regardless of obvious injuries.

In conclusion, intimate partner violence victims seeking help from criminal justice utilize emergency care at extremely high rates, especially near the time of the police-identified intimate partner violence assault. Most of these visits, even injury-related visits, occur without identification or referral to intimate partner violence resources. This study highlights the profound disconnection between the real-life conditions underpinning patient health and the system-based response demonstrated by the EDs in these 2 hospital systems. The extensive ED utilization by police-identified intimate partner violence victims provides further evidence that we cannot abandon efforts to improve intimate partner violence screening and referral in ED settings. Study findings also confirm the complex nature of ED utilization by intimate partner violence victims, a utilization that is substantial but often hidden. This complexity presents multiple challenges to hospital systems, particularly EDs, which are already overburdened by growing utilization and shrinking reimbursements. Nonetheless, the costs, both financial and human, are too high and the opportunities too real to ignore.

The authors wish to thank Patricia Smith, MS, director, Violence Against Women Prevention Program, Michigan Department of Community Health; the Kalamazoo Assault Intervention Program; James Wiley, PhD, Catherine Cerulli, JD, PhD, the Borgess and Bronson ED staff, the many research assistants who worked on this project, and Debra E. Houry, MD, MPH, and the 4 anonymous reviewers.

Supervising editor: Debra H. Houry, MD, MPH

Author contributions: The authors contributed equally to all phases of the project from conceptualization to manuscript preparation. KR takes responsibility for the paper as a whole.

Funding and support: This project builds on data collected during the MEDCIIN Projects, collected under a Centers for Disease Control and Prevention cooperative agreement U17/CCU551067. The current work was supported by National Institute of Mental Health grant K23/MH 64572 (Rhodes) and by the Borgess Research Institute (Kothari).

Publication dates: Received for publication June 1, 2005. Revisions received August 5, 2005, and September 27, 2005. Accepted for publication October 17, 2005.

Presented as an abstract at the National Conference on Health Care and Domestic Violence: Health Consequences over the Lifespan, Boston, MA, October 2004; the 2005 National Injury Prevention and Control Conference: Violence in America, Denver, CO, May 2005; and the annual conference of the Society for Academic Emergency Medicine, New York, NY, May 2005.

Reprints not available from the authors.

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CORRECTION

In the November 2005 issue, in the article by Judge et al ("To Dive or Not to Dive? Use of Hyperbaric Oxygen Therapy to Prevent Neurologic Sequelae in Patients Acutely Poisoned with Carbon Monoxide"; pages 462-464), the Take Home Message should have read, "It remains unclear which patients with carbon monoxide poisoning will require treatment with hyperbaric oxygen therapy. Further research is needed to define which patient subgroup, if any, will benefit from the use of hyperbaric oxygen in the setting of acute carbon monoxide poisoning." The authors and publisher apologize for any confusion this may have caused readers.

Intersections

Domestic Violence and Allied Organizations Partnering for Health

June 2013

Support provided by:

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Table of Contents

Introduction

The country enters 2013 facing unprecedented policy developments in women's health. On one hand, we are approaching full implementation of the Patient Protection and Affordable Care Act (ACA), which heralds a more integrated approach to health care, facilitated in part by formal partnerships. On the other hand, in one last act of inaction, the exiting 112th Congress allowed the Violence Against Women Act (VAWA) to expire for the first time in almost 20 years. (Its subsequent passage on February 28 was a hard-fought victory after months of uncertainty.) In short, the past year has seen crippling rollbacks one moment and breakthroughs the next for women's health.

For domestic violence organizations, this means there has been no more critical time to strengthen ties with health care providers and other partners to ensure that women, children, families, and communities have access to the full array of supports needed to live healthy lives free from violence.

For decades, advocates have worked to bring visibility to domestic violence not as a private issue but as a community concern, including its health impacts. In the mid-80s and early 90s, recognition of this connection to health gained support among policymakers and providers. However, while many continue to encourage collaboration among domestic violence agencies and health care providers, such partnerships are still rare.

In 2012, Blue Shield Against Violence (BSAV) released *The Power of Partnership* series of reports describing how integrated efforts among domestic violence organizations and service providers in other allied disciplines can enhance services, expand reach, and create a stronger community voice for ending violence.

Intersections continues that exploration, with a focus on relationships between domestic violence and health care. For practical reasons, this report highlights the intersections in primary care and mental and behavioral health as two broad categories of health services. This is not to suggest these are the only areas where domestic violence agencies may be valuable partners, it merely serves as a means of illustrating some of the issues and opportunities at hand.

Written for a diverse audience of domestic violence advocates, health providers, and allied organizations, this report seeks to:

1. Shed light on how organizations are working in the intersection between domestic violence and health
2. Provide an overview of the ACA's impact on domestic violence services
3. Highlight opportunities for partnership between providers in domestic violence and those in primary care and mental health
4. Identify key competencies needed for successful collaborations

This report serves as an invitation for domestic violence agencies and health care organizations to explore how to share their strengths to deliver client-centered services and solutions to survivors of domestic violence.

Domestic Violence and Health

Modern History and Evolution

The modern domestic violence movement in the U.S. traces its roots at least as far back as the late-1960's when the first women's shelters began to open their doors and offer safe haven. It was not until some twenty years later that advocates' efforts at raising awareness gained traction in exposing domestic violence as a public health issue. In a series of advances and temporary setbacks, new data, resources, and relationships emerged, leading to increasingly coordinated responses among policymakers and providers. By the mid-1990s, the role of the health care provider community in identifying domestic violence and helping patients to access appropriate supports was becoming more widely recognized.

The timeline on the following page highlights just a few of the developments that have brought domestic violence advocacy and health care into closer intersection.

Virginia Duplessis describes this trajectory from her own vantage point, first as an advocate and now as program manager of Project Connect for Futures Without Violence: [i]

> *"I started as an advocate in 1992, and at that time criminal justice was the big focus. Getting a woman to file a restraining order was seen as the end-all be-all. When additional research and experience began to point out the broader impact of violence, health was one of the first places. Obviously, there was the ER visit connection to be made, but now we are learning more about intersections with chronic health conditions (mental health, diabetes, obesity, etc.). We are seeing more of the connections."*

Domestic Violence Correlates to Top Health Issues

Domestic violence is a risk factor associated with 8 out of 10 of the leading indicators for national health promotion and disease prevention initiative, Healthy People 2010.[ii]

- Tobacco Use
- Injury and Violence
- Responsible Sexual Behavior
- Immunization
- Substance Abuse
- Mental Health
- Health Care Access
- Obesity

Even with this direct link between domestic violence and health, domestic violence and other human service providers are just beginning to become aware of the potential impact the ACA will have on their work and their clients. The sooner domestic violence providers join other health and human services providers to prepare for the ACA, the better positioned they will be to make sure domestic violence issues are integrated into overall health care programs. Implementation of the ACA and its implications for health care providers, domestic violence agencies, and other allied organizations is therefore touched on throughout this report.

Stepping Stones in the Recognition of Domestic Violence as a Public Health Issue

1972	Women's advocates establish the first shelters for battered women and their children.
1979	Congress holds hearings on the issue of domestic violence for the first time. The Carter Administration creates the Office on Domestic Violence as part of the U.S. Department of Health, but the office closes in 1981.
1984	Family Violence Prevention and Services Act is authorized, creating funding dedicated to domestic violence shelters and programs. It expires in 2008, but advocates fight to have FVPSA reauthorized in 2010.
1985	U.S. Surgeon General C. Everett Koop issues a report calling for public education and the education of health professionals about the causes and consequences of various forms of domestic violence.
1988	The Surgeon General declares domestic abuse as the leading health hazard to women in the U.S.
1990	Healthy People 2000 objectives for public health specifically address the reduction of violence against women, including reducing the rate of physical assault by current or former intimate partners.
1993	The U.S. Department of Health and Human Services funds creation of the Domestic Violence Resource Network, including the National Health Resource Center on Domestic Violence (HRC).
1994	The Centers for Disease Control and Prevention and the National Institute of Justice partner to administer the National Violence Against Women Survey. Conducted in 1995-1996, this survey provides the first national data on the incidence and prevalence of intimate partner violence, sexual violence, and stalking.
1996	The American Medical Association launches a Campaign Against Family Violence to raise physician awareness and improve diagnosis, treatment, and prevention. It also begins to develop and publish professional guidelines for physicians' response to domestic violence.
2011	The Institute of Medicine issues a recommendation that screening for intimate partner violence become mandatory under the Patient Protection and Affordable Care Act.
2012	Per the Patient Protection and Affordable Care Act, eight services are to be provided to women without any cost-sharing requirement – this includes screening and counseling for domestic violence.

The Patient Protection and Affordable Care Act

The ACA in Brief

The new health care reform law is multifaceted and complex, but for most of us its meaning centers on two themes: coverage and access.

- Beginning in 2014, health insurance will be extended to more than 30 million individuals through either Medicaid or subsidies and exchanges designed to ensure access to affordable private coverage. This will create new demand for health care services and more access to providers offering prevention education and services.
- The influx of new health care consumers will put more pressure on an already strained primary care system. Estimates suggest that 63,000 more physicians will be needed by 2015 to ensure that the system can meet increased demand for services.[iii] Health coverage will not necessarily guarantee health access.
- For more than 20 million people, health coverage will remain elusive. One in four of these will be ineligible for coverage under the ACA due to immigration status.[iv] Safety net and other community health providers will be challenged to serve both the newly insured and self-pay or uncompensated clients.

In addition to expanding coverage, the ACA mandates the use of quality measures, enhanced public reporting, and pay-for-performance mechanisms in attempts to make health care more patient-centered. For example, ACA incentives encourage health care providers to adopt a “medical home" approach to coordinated care as well as the creation of Accountable Care Organizations in which providers collaborate to ensure quality care and realize Medicaid cost savings. These developments point to a more integrated approach to health care, facilitated in part by formal partnerships.

Helpful Definitions

The Patient Centered Primary Care Collaborative defines the **medical home** (or Patient-Centered Medical Home) as “a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.” The term describes not a service location, but an ideal for how primary care should be organized and delivered. The ACA calls for an even more comprehensive Patient-Centered Health Home, inclusive of community-based prevention services. Several programs in the ACA promote such models, though many are not yet fully funded due to federal budget constraints.[v]

The Urban Institute defines the **Accountable Care Organization** (or ACO) as a local health provider collaborative (including, at a minimum, primary care physicians, specialists, and hospitals) that can be held jointly accountable for the cost and quality of care delivered to a defined population of patients. ACOs receive financial incentives for achieving quality and cost reduction goals through coordination of care. This structure is still relatively new; as such, requirements for implementation are still being refined.[vi]

The ACA and Women's Health

The ACA expands women's preventive health care, requiring that insurance companies provide eight types of services with *no patient cost-sharing requirement*.

1. **Well-woman visits**, which includes an annual preventive care visit for adult women and follow-up visits as deemed necessary by the woman and her provider
2. **Gestational diabetes screening** for pregnant women at 24 to 28 weeks, and others at high risk of developing gestational diabetes, which puts women at increased risk of developing type 2 diabetes following pregnancy
3. **HPV DNA testing** every three years for woman age 30 or older (HPV, or human papillomavirus, is the most common sexually transmitted infection (STI) in the U.S.)
4. **STI counseling** on an annual basis for sexually active women
5. **HIV screening and counseling** on an annual basis for sexually active women
6. **Contraception and contraceptive counseling**, including access to all FDA-approved methods of contraception and sterilization procedures (though with the exception of abortifacient drugs like RU-486)
7. **Breastfeeding support, supplies, and counseling** for pregnant and postpartum women
8. **Interpersonal and domestic violence screening and counseling** for all adolescent and adult women, for the purposes of early detection and effective interventions

Additionally, the ACA now prohibits insurance companies from treating pregnancy or domestic violence as a "pre-existing condition," meaning that domestic violence survivors will have fewer barriers to coverage.

The ACA poses an array of new opportunities and challenges for both the domestic violence and health care fields. Health professionals will have a new role to play in screening and providing limited counseling. This provides a tremendous opportunity for domestic violence organizations to reach out to the medical community to offer training, support, and partnership.

With 47 million more women now having guaranteed access to preventive services, and an estimated 25% of all American women experiencing intimate partner violence in their lifetimes, many more women will likely be identified as requiring survivor services. This could translate to an influx of more referrals to domestic violence organizations, or health care organizations may expand services in-house. If the former, this will test the capacity of domestic violence agencies to serve more clients while at the same time ensuring effective referrals and transitions. If the latter, advocates must create a role for themselves as partners with health care to ensure that services are responsive and appropriate.

A Policy Perspective: Futures Without Violence

In order to better understand the need and potential for closer collaboration among domestic violence advocates and health care providers, and the impact of the ACA on these efforts, we spoke with Kiersten Stewart, Director of Public Policy and Advocacy at Futures Without Violence.

Futures Without Violence is the premiere resource on the intersection of domestic violence and health care, and currently houses the National Health Resource Center on Domestic Violence. Founded in 1980 as the Family Violence Prevention Fund, the organization was one of the first to consider how to reach women before they seek advocacy services or go to the police, and it saw an annual health visit as a prime opportunity to do screening for domestic abuse. Today, Futures Without Violence provides education and training, resources, and policy advocacy to support domestic violence advocates, as well as allied professionals and organizations, in bringing an end to abuse. Passage of the ACA and its call for increased involvement of health care providers in screening and counseling for domestic violence now offers the potential to amplify this work.

The new legislation does not mean the hard work is over. “In fact,” Stewart says, “it means it’s beginning again, and in a new and bigger way. Now that domestic violence screening and counseling is one of the eight services guaranteed to women through the ACA, the question is how to build broader awareness of the health impact of violence, strategies for reducing the harm, and the incredible opportunity to save lives by helping women get safe from the violence sooner.” This is a challenge for health providers, she says, noting that “even our long-term allies in public health don’t automatically make these connections.” It is also challenging for advocates to partner around this intersection of issues because there is such a scarcity of resources for domestic violence services.

“Many domestic violence shelters are getting by on a shoestring [budget], making it hard for them to do the life-saving work of providing emergency shelter and services, let alone build linkages with health care providers,” Stewart says. “It feels like yet another burden.” But she stresses the importance of building these relationships, saying that “we have to expand the resources that will support the work of connecting health care systems to advocacy and supportive services because collaboration, and coordinated response, is what survivors need most.” Stewart sums up the dual opportunity and challenge posed by the ACA:

> *“This is the best opportunity we’ve had to engage domestic violence advocates in 25 years, but we need to help them succeed. If there are no resources to help them be at the table, the promise of the ACA to help survivors and improve health may go unrealized. We can’t let that happen. That’s why this is such an important time.”*

Domestic Violence and Primary Care

The following section explores some of the issues and opportunities at the intersection of domestic violence and primary care, largely by highlighting lessons from existing efforts.

One of the areas in which the potential crossover between domestic violence advocacy and health care was first recognized is emergency room admissions. Although collaborative efforts designed to enhance services in this setting have resulted in important improvements, they come into play only after a serious injury has occurred. Domestic violence services can also be aligned with preventive health care by integrating education, screening, and other services in non-emergency primary care settings such as community health centers, or CHCs.

Community Health Centers

The health care field is broad and varied, but in this paper we want to especially highlight the role of nonprofit community health centers, or CHCs. CHCs are nonprofit safety net health care providers, and they include free clinics (which are supported by private contributions) and Federally Qualified Health Centers (FQHCs) or FQHC "look-alikes" (which receive funds from Federal Block Grants and Medicaid reimbursements).

CHCs can be found in every community and provide a range of primary care and health education services. Some also provide mental and behavioral health care, dental care, prenatal and perinatal care, and supportive services and programs such as case management, transportation, enrollment assistance, and community outreach. In 2010 in California, there were more than 100 FQHCs alone (not counting free clinics or look-alikes) operating more than 1,000 sites serving nearly 3 million people.

Project Connect is a national program seeking to strengthen the connection between primary care and domestic violence advocacy. Here, program manager Virginia Duplessis shares a little about this initiative and what has been learned about successful collaboration.

Project Connect

Administered as a program of Futures Without Violence, Project Connect was created by the Violence Against Women Act reauthorization in 2006 and launched in 2010 with funding from the Office of Women's Health. In its first two-year pilot, it provided training and support to 10 grantees (eight states and two organizations working with Native American communities in California), helping them to forge collaborations between the public health and sexual and domestic violence fields. It selected participants for its second grant round in 2012.

The launch of Project Connect benefited from a confluence of three key factors: 1) an increasing focus on home visitation programs, for which public health departments were beginning to see new federal dollars; 2) emerging evidence and awareness of reproductive coercion, in which birth control sabotage and unwanted pregnancy is part of the cycle of violence; and 3) growing support of programs to educate adolescents about healthy relationships.

Project Connect was well positioned to take on these issues. With more attention being drawn to these intersections between domestic violence and health, there was now greater opportunity to recognize a broad range of health impacts as well as different venues for intervention beyond the ER, including primary care clinics, women's health clinics, home visitation programs, and schools. As Duplessis notes, "Lots of women never go to the ER, but they *are* seeking family planning and women's health services, or receiving home visitations," making these important points of entry to domestic violence services.

Project Connect educates health care providers about the connection between violence and negative health outcomes, encourages partnerships with local domestic violence programs to facilitate referrals, and gives them them strategies they can implement as health care providers to help patients experiencing domestic violence, such as offering women undetectable and untamperable birth control to address reproductive coercion. It also works with domestic violence advocates, equipping them with harm reduction strategies (such as asking clients about unwanted sex and offering birth control) and preparing them to make effective referrals to the community health programs. "The domestic violence advocate provides an important link, like a 'concierge,' to lots of other resources," says Duplessis. "Many women don't know what they're eligible for or have access to, and advocates can help pave the way and provide those connections to needed services."

Reproductive Health and Home Visitation Programs

One of the key issues Project Connect seeks to address is reproductive coercion, or an abuser's attempts to manipulate an unintended or unwanted pregnancy through forced intercourse or birth control sabotage. Because the program involves state public health departments as a partner, it can facilitate access to contraception, pregnancy tests, and other resources. Project Connect also has a policy component, engaging partners in efforts to update family planning policies to include reproductive coercion in their standards and mandating training for providers.

Lisa James, Director of Health for Futures Without Violence, says of the ACA's implications on integrating domestic violence and health care: "Adolescent and reproductive health, and also home visitation, are where you're going to see it."

Her organization has already partnered with FPACT, California's family planning program providing reproductive health care services to women and men at or below 200% of the poverty level, to prepare the program's 3,200 providers to assess and intervene for reproductive coercion as part of routine care. This is the largest statewide initiative on reproductive coercion, reaching potentially 1.6 million women with information and support around reproduction and domestic violence. James added that for the past year, Planned Parenthood's national guidelines have mandated that its 850 clinics screen for domestic violence and reproductive coercion and provide a warm referral to local programs.

James explains that the ACA legislation added new state benchmarks requiring that maternal, infant, and early childhood home visitation programs screen for domestic violence and provide safety planning. "This means that if home visitors are doing their job right, they should be reaching out to local domestic violence programs," she says. "Advocates who don't know about these policy changes may not know why they're suddenly getting more requests for training."

Another focus of the program is to develop models for how domestic violence organizations can integrate health into their scope of work, including advocates providing basic health assessments on site, and/or inviting health providers to come in on a regular basis to offer clinical health services on site. Project Connect engages multidisciplinary teams in developing and institutionalizing policies and protocols, emphasizing the importance of having both sides at the table when program decisions are being made. “We want that all to be in writing,” Duplessis explains, “to make sure that when health center intakes are developed, the advocates are part of that team, to make sure it’s done right. At same time, when advocacy programs put together their processes, we want the health folks to be part of that discussion.”

Project Connect staff hosted monthly calls, bimonthly webinars, annual site visits, and twice yearly national meetings that incorporated formal training as well as peer learning. “It was really powerful, being able to learn from others,” Duplessis says. “Traditionally, the public health and violence fields have been siloed, even within their own fields, not to mention across states. To be able to hear what’s going on elsewhere…it’s really great to see the light bulbs going on.”

However, barriers still exist that must be overcome. Some of these include:

- *Time.* Health care providers may hesitate to engage because of concerns that adding assessment or interventions could take too much time, thus impacting their patient load. Likewise, domestic violence advocates may already feel overloaded and reluctant to take on “one more thing.” But in both cases, Duplessis says, “We can show them that it only takes a couple extra minutes.”

- *Referral resources.* It is important that when a health care provider has a patient who has disclosed domestic abuse, there are advocates ready to step in and take the handoff. Domestic violence advocates may themselves harbor concerns about referring clients to health care providers if there is any doubt in the provider’s sensitivity or skill in serving survivors of abuse. Forging and maintaining strong referral relationships, and making “warm” handoffs whenever possible, can help to assuage such concerns.

- *Confidentiality.* “This is always a sticky-wicket,” Duplessis says, “though sometimes it gets raised when there are other underlying issues because it’s the easiest barrier to throw up to slow things down. It’s critically important to work out confidentiality issues at the outset, and then move beyond them.

- *Funding and political support.* The political and funding climate has changed since 2010 when Project Connect was first launched. Domestic violence nonprofits are vulnerable to cuts in government funding, and public health programs are also struggling financially. Fortunately, willing partners can still be found among both groups.

Despite these challenges, success breeds success, and providing one positive experience with collaboration often opens the door to another. Duplessis reflects on the impact of Project Connect's initial pilot:

> *"The relationships have grown so much. Working on Project Connect has expanded to other parts of their work. The public health programs started working on sexual and reproductive health, making sure women in shelters have designated appointment times, and reducing wait times, etc., but many are saying 'now we have this relationship, maybe we can do more.' They're working on getting things like free flu shots for women at the shelter, or free car seats for the kids. The initial relationship created lots of other opportunities for other collaboration, at low cost, and for less effort than you would think."*

At its best, collaboration is looking at where values, interests, and priorities intersect, and what strengths, approaches, and resources each partner can bring to the table to achieve results.

What Does Collaboration Look Like?

Lisa James sees collaboration between domestic violence and health playing out in many different ways. "Having an advocate on site, where the advocate is a core part of the health care team, is one of the most comprehensive approaches," she says. "Many communities don't have that luxury, though. In some cases, it's more about having an advocate on call who can come to the health care setting, or maybe a strong MOU around direct referrals. In small or rural communities, none of these may be possible, and the best option may be for the health care provider to link patients with the National Domestic Violence Hotline."

Futures Without Violence has led numerous efforts to support collaborative relationships, particularly in a public health setting. Based on its experience, it identifies these core elements of success:

- Create an environment that prioritizes the safety of victims including respecting the confidentiality, integrity, and authority of each victim over their own life choices
- Create an environment that enhances rather than discourages discussion about abuse and its health impact
- Build the skills of health care staff so that they understand the dynamics of violence and abuse; are able and willing to assess for abuse; and can effectively respond to victims and their children
- Establish an integrated and institutionalized response to violence and abuse
- Develop culturally appropriate responses and resource materials
- Evaluate, on an ongoing basis, the effectiveness of the program
- Becoming part of a coordinated response within the larger community through collaborative partnerships with local violence and abuse programs and others

James adds that more effort is still needed to support collaboration. "People need to see models of collaboration and the need for domestic violence organizations to be supported in doing this work."

Domestic Violence and Mental & Behavioral Health

The following section explores some of the issues and opportunities at the intersection of domestic violence and mental health, largely by highlighting lessons from existing efforts.

Domestic violence has a profound impact on survivors' mental health, and can be a precipitating factor in substance abuse. At the same time, women with existing mental health diagnoses and/or substance abuse issues are also at greater risk of abuse. This makes it essential that providers treating mental health and substance abuse understand how to best serve survivors of domestic violence, as well as for domestic violence advocates to have the knowledge and relationships enabling them to effectively link clients to appropriate mental health and substance abuse resources.

The Impact of Abuse on Mental Health

A study published in the *Journal of the American Medical Association* in August 2011 underscored the importance of providing more closely integrated mental health services for survivors of domestic abuse.[vii] The research, conducted in Australia, found that women who had experienced at least one form of abuse including intimate partner violence, rape, sexual assault, or stalking were almost three times more likely to report a mental health condition than those who had not. Mental health effects included mood disorder, anxiety disorder, substance abuse, and post-traumatic stress disorder. Women who were victims of violence also had a near threefold increased risk of suicide.

Although many domestic violence organizations already provide a broad range of non-shelter services, including counseling and other mental health supports, the need continues to be great. In a 2011 report, the National Resource Center on Domestic Violence (NRCDV) and the University of Connecticut School of Social Work detailed the results of a four-state survey on survivor needs and the provider community's efforts to meet them.[viii] The majority (88.5%) of the nearly 1,500 survivors surveyed expressed interest in counseling options, and 4 in 10 respondents specifically asked for assistance with mental health services.

In Washington state, the King County Coalition Against Domestic Violence (KCCADV) has led a team of partner agencies in a multi-year effort to improve services for survivors of domestic violence with mental health concerns by strengthening collaboration. Below, Project Coordinator Alison Iser talks about these ongoing efforts and some of the key takeaways to date.

The Domestic Violence and Mental Health Collaboration Project

Supported by grant funds from the Department of Justice's Office of Violence Against Women, the Domestic Violence and Mental Health Collaboration Project (the Collaboration Project) was initiated in 2007 and is now entering its third round of funding. Originally sponsored by the City of Seattle Human Services Division, the program is now administered by KCCADV. Its purpose is to facilitate sustainable systems change within and among partner organizations to better meet the needs of survivors of domestic violence who are also experiencing mental health concerns.

For the past five years, the Collaboration Project has worked with four provider partners: one multi-service agency with domestic violence programs, one organization working primarily in domestic violence, and two mental health organizations. The first year and a half was spent assessing their strengths and gaps in service and in planning for how they would work together. Then, in 2009, they launched four initiatives: 1) create more welcoming environments to increase clients' comfort in accessing services; 2) enhance knowledge of domestic violence for mental health service providers, and vice versa (through online courses); 3) Improve response by strengthening issue identification and interventions (resulting in a cross-disciplinary approach to service delivery); and 4) strengthen collaboration among partner agencies and among service providers within agencies (in part through cross-disciplinary case reviews).

In 2011 and 2012, the partner organizations engaged in reflection and learning activities and identified four new initiatives to build on their previous work. This included: 1) adapting online training courses for non-partner agencies and other national audiences; 2) integrating trauma-informed practices into care and supervision; 3) developing a reciprocal consultations guide; and 4) offering co-facilitated support groups.

The Trauma-Informed Approach

Carole Warshaw, MD, director of the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH), explains that "trauma informed" is used to describe organizations and practices that incorporate an understanding of the pervasiveness and impact of trauma, and that are designed to reduce retraumatization, support healing and resiliency, and address the root causes of abuse and violence. This approach understands "symptoms" as potential survival strategies, or adaptations may be made to highly traumatic situations when real protection is unavailable and normal coping mechanisms are overwhelmed.

Warshaw describes the impact of trauma theory on the provision of mental health services: "It helped to destigmatize the mental health consequences of violence by recognizing the role of external events in generating symptoms, and it ultimately created a more holistic framework for understanding the biological, emotional, cognitive, and interpersonal effects of abuse." A trauma-informed approach focuses not only on the psychological harm, but also on individuals' resilience and strengths. A trauma framework also fosters an awareness of the impact of this work on providers, emphasizing the importance of provider self-care and other supports.

(continued)

By providing training and technical assistance on providing accessible, culturally relevant, and trauma-informed responses to domestic violence, the work of NCDVTMH is not only to build the capacity of domestic violence and allied organizations to take a trauma-informed approach, but also to bridge a trauma lens with a domestic violence advocacy lens. Because for many survivors of domestic violence, trauma is not only in the past but ongoing, their "symptoms" may reflect a response to ongoing danger and coercive control. At the same time, stigma associated with substance abuse and mental illness allows abusers to use these issues to further abuse and control their partners. For these important reasons, says Warshaw, "a combined trauma- and domestic violence-informed approach is critical in both health and behavioral health settings."

Sharing the trainings allowed the Collaboration Project to inform others about their model, which was already gaining some recognition. Adding a trauma-informed approach to their work meant training partner staff and then supporting each agency in integrating this approach in a way that made sense for them. (See preceding text box for more on trauma-informed care.) Reciprocal consultations formalized a practice of having an advocate available to meet with a group of therapists, and vice versa, while co-facilitated support groups allowed clients to draw on the combined expertise of both domestic violence and mental health staff.

Some of the lessons learned throughout the past five years of the Collaboration Project include:

- *Take time to plan.* The project started with a planning phase during which it articulated its purpose in a written charter. Iser explained "the charter wasn't just about *what* we were going to do, but *why* and *how* we were going to do it, our aligned values, shared goal, and common ground." Two other elements of the planning phase were to assess partner agencies, and to ensure the right people were involved. Iser said that the opportunity to learn more about their needs and strengths better prepared the partners to take on a collaborative effort. She also said that it was important that the project involved representatives from each partner agency who had significant influence at their respective organizations, which aided in instituting new collaborative practices.
- *Never make assumptions.* Communicating across disciplines can be like speaking two different languages. Iser reflected: "Sometimes we lose something by assuming we have so much in common and fail to pay attention to what's different. For example, we may use the same word, like "confidentiality," but we actually use that term somewhat differently. It can create tensions when we assume we mean the same thing when the fact is we use language differently. We came up with a glossary to help point that out.

- *Cross-disciplinary collaboration occurs within agencies.* Stronger integration between domestic violence and mental health services is not only a matter of collaboration across organizations, but *within* organizations. One partner agency had both domestic violence and mental health staff, but they were not working in concert. This initiative equipped the organization to better coordinate services, improve the quality of cross-departmental referrals, and work more effectively as a team.

- *Collaboration requires investment.* The success of initiatives like the Collaboration Project is due in no small part to the fact that that they are supported by paid staff. Having staff time set aside specifically to coordinate project activities is critical. Iser said: "People have to actually invest in collaboration. It doesn't just magically happen." It also requires an investment of time. Although it can take a while to get started (especially if engaging in thoughtful planning at the beginning), this ultimately saves time in the end.

Iser shared a story about how the initiative has impacted how partner agencies work together to provide client services.

> *"There have certainly been times when partner agencies have both served the same person in common. In the past, they probably wouldn't have had any communication across agencies, but now we're seeing cases where they're doing release of information forms and sharing information to make sure clients' needs are getting met. There was one instance where a client complaint arose, and the two agencies came together to figure out what was going on. They discovered that miscommunication had led to an unfortunate misunderstanding, and that this client could be better served in the future by providing language translation services. In the past, this issue could have led to friction between the two organizations, but here we were able to quickly address the problem and move forward."*

Based on its success to date, the Collaboration Project is now working with partners from the civil legal system to better meet the needs of survivors of domestic violence who have mental health concerns and who are involved in protection order or family law cases.

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Cross-Disciplinary Partnerships: Key Competencies

The nonprofit sector is beginning to observe a move toward closer integration between primary health care and mental and behavioral health care, in response to the ACA's comprehensive and holistic vision of health and wellness. The ACA's promotion of the Patient-Centered Medical Home model is just one way that mental and behavioral health services may become more closely coordinated with primary health care. The Substance Abuse and Mental Health Services Administration (SAMHSA) is also supporting a range of other efforts to help community-based health agencies initiate or expand service integration, especially for people in treatment for mental illnesses and co-occurring substance abuse issues.

Many expect this to be just the beginning, with more integration of other services close to follow.

Since the passage of health care reform, various types of nonprofits have begun to try to define what the ACA means for them. For example:

- In January 2013, Shared Action, a capacity building assistance program of the Los Angeles AIDS Project, hosted a webinar on what HIV/AIDS services organizations should be prepared for under the ACA.[ix] The main thrust of the webinar was that given sea changes specific to HIV/AIDS services policy and financing, in addition to ACA-related shifts, more organizations may want to use strategic restructuring to consolidate their strengths and better position themselves for the future.

- In September 2012, Grantmakers in Health released an issue brief making the case for closer integration of oral health care and primary care.[x] The report, "Returning the Mouth to the Body: Integrating Oral Health and Primary Care," acknowledges that ACA ushers in new pay-for-performance payment mechanisms that could facilitate this integration, but it also notes that the roll-out of these new structures is still just getting underway.

- In August 2012, the SCAN Foundation, a funder dedicated to the health care needs of seniors, issued "Overview of Preparing Community-Based Organizations for Successful Health Care Partnerships." Written for long-term care organizations, the paper focuses on opportunities to provide care transition services to support hospitals in reducing readmissions.[xi] The author identifies competencies needed for collaboration, including making a business case, excellence in service delivery, and evaluation capacity.

This is just a sampling of the initial analysis of the opportunities posed by health care reform for health and human services nonprofits. A key theme among these is that the funding streams and financing mechanisms supporting such collaborative and integrative efforts have yet to be well defined. Lisa James confirmed similar implications for domestic violence organizations, and said that Futures Without Violence will soon be seeking clarification on whether domestic violence advocates working as part of health care teams could be reimbursed for their services.

Although much is still unclear about how the ACA rules will play out in practice, these various attempts to anticipate and understand what it means are valuable in surfacing some of the key competencies that community based organizations will likely need to in order to attract, engage, and collaborate with health care partners.

These competencies include:

Service Capacity: One of the primary challenges of health care reform will be to match the millions of newly insured with access to health care services. Shortages are already anticipated. Organizations that can effectively accept a high volume of referrals for complementary services will be most valuable to health care providers struggling to serve this new influx of patients.

Systems Capacity: The health care sector is transitioning to more up-to-date health information technology to facilitate care coordination, management of patient records, and reimbursement and billing systems. With this increasing sophistication, health providers may expect partner organizations to have systems, skills, and infrastructure that can keep pace with information sharing and/or other communications needs.

Technical Capacity: Organizations that seek partnerships with health care providers may need to be able to set fees appropriately, manage different funding streams, and navigate regulatory issues, particularly if being reimbursed for services. Although domestic violence organizations already operate under specific mandates and restrictions, health care providers bring their own set of expectations and requirements that may come into play in a collaborative setting.

Value Proposition: It is always important for an organization to be clear about what it seeks to achieve through collaboration and what assets or strengths it can offer a potential partner. This is especially critical when reaching across sectors and disciplines. There must be a strong case for collaboration that demonstrates the qualitative and quantitative benefits.

Community Connection: Domestic violence organizations and other community-based service providers often have unique relationships with the community that can make them attractive partners in shared efforts to reach certain populations or advance specific issues. For example, socially or culturally marginalized populations may feel more comfortable with domestic violence agencies and other community-based service providers than with health care institutions. Similarly, organizations that have earned a reputation as the community voice for a shared goal like ending violence or improving child and family health also bring a complementary strength that can be desirable to a health care partner.

Proven Ability to Partner: It takes skill to be a good collaborator—to focus on the shared goal, to foster trust, to model openness and transparency, and to be a good communicator. Agencies that have already engaged in successful partnerships are often the ones to seek out more such opportunities. They are also more often sought out by other organizations seeking to partner.

Finally, it must be noted that although health care providers may be increasingly inclined to partner with organizations that can help them fulfill their new obligations under the ACA, these same health care providers are under pressure to make any number of changes in how they work to adapt to the still-shifting and uncertain new health care environment. As such, they are dealing with competing priorities. This suggests that domestic violence and allied organizations seeking to collaborate with health care providers will be most successful if they approach partnership from a place of strength, with a clear rationale, demonstrated capacity, excellence in service delivery, and experience in navigating collaborative relationships.

Next Steps and Resources

The intersection between domestic violence and health care services is a dynamic one that is continually evolving. Today, implementation of the ACA appears to herald a more collaborative approach to providing health care and related services, yet it is still unclear how such collaboration will be structured and supported.

What we can say with some confidence is that by formalizing the role of primary care providers as a point of access for survivors of domestic violence, it suggests an opportunity for domestic violence agencies to serve as expert partners, helping health care professionals provide helpful services and referrals. At the same time, this new role for health care providers may pose a kind of competition, if they begin to perform "in-house" those services domestic violence agencies would normally provide. In both cases, domestic violence organizations will need to decide how to position themselves in this evolving new context. Allied service providers of all types may also find themselves facing similar questions.

Following are just a few of the organizations and publications that can help inform your organization's plans to respond to this changing service delivery landscape.

Futures Without Violence

www.futureswithoutviolence.org/section/our_work/health

ACA Fact Sheet on Preventive Services for Women

www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html

National Center on Domestic Violence, Trauma & Mental Health

www.nationalcenterdvtraumamh.org/

Endnotes

[i] Futures Without Violence houses the National Health Resource Center on Domestic Violence and hosts the National Conference on Health and Domestic Violence. The organization offers an array of resources for domestic violence advocates and health care providers on how to better integrate domestic violence and health. We are indebted to FWV for its contributions to this research report. For information, please visit: http://www.futureswithoutviolence.org/section/our_work/health

[ii] Domestic & Sexual Violence Information [Webpage] Virginia Commonwealth University, Institute for Women's Health http://www.womenshealth.vcu.edu/outreach/domesticviolence/index.html

[iii] "Prognosis Worsens for Shortages in Primary Care," [Podcast and Transcript], National Public Radio, August 7, 2012 http://www.npr.org/2012/08/07/158370069/the-prognosis-for-the-shortage-in-primary-care

[iv] "Millions Still Uncovered with Health Law Expansion," [News Blog] by Kyle Cheney, Politico.com, May 23, 2012 http://www.politico.com/news/stories/0512/76692.html

[v] What is a Medical Home? [Webpage] Patient-Centered Primary Care Collaborative http://www.pcpcc.net/what-we-do

[vi] "Can Affordable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" [Issue Brief] by Kelly Devers and Robert Berenson, The Urban Institute, October 2009 http://www.urban.org/uploadedpdf/411975_acountable_care_orgs.pdf

[vii] "Violence Takes Mental Health Toll on Women," [News Blog] by Kristina Fiore, Medpagetoday.com, August 2, 2011 http://www.medpagetoday.com/PrimaryCare/DomesticViolence/27866

[viii] "Meeting Survivors Needs," [Final Report], University of Connecticut School of Social Work and National Resource Center on Domestic Violence, November 2011 http://www.vawnet.org/Assoc_Files_VAWnet/DVServicesStudy-FINALReport2011.pdf

[ix] "Strategic Restructuring in the Affordable Care Act Era: The New Role of the HIV CBO," [Video] Shared Action, January 17, 2012 http://youtu.be/-_LQ7fvGmSU

[x] "Returning the Mouth to the Body: Integrating Oral Health & Primary Care," Grantmakers in Health, September 26, 2012 http://www.gih.org/Publications/IssueDialogueDetail.cfm?ItemNumber=5005

[xi] "Overview of Preparing Community-Based Organizations for Successful Health Care Partnerships," by Victor Tabbush, the SCAN Foundation, August 2012 http://www.thescanfoundation.org/victor-tabbush-overview-preparing-community-based-organizations-successful-health-care-partnerships

The Affordable Care Act:
What you need to know about Health Reform

(THIS IS AN INTERACTIVE PDF, **CLICK ON GRAPHIC ELEMENTS** TO OPEN WEB-LINKS FOR MORE INFORMATION)

OVERVIEW

The Affordable Care Act (ACA) focuses on increasing the number of Americans who have health insurance by reducing costs and restrictions to insurance through Insurance Exchanges, expanding Medicaid benefits to more people, requiring businesses with 50 or more employees to provide insurance to their workers, and offering preventive services at no cost, giving special attention to women and children.
(For more information, see the Kaiser Family Foundation report[i]).

Medicaid Expansion

More people will be eligible to enroll in Medicaid: All childless, non-Medicare eligible adults (under age 65) whose income is up to 133% of the Federal Poverty Level.

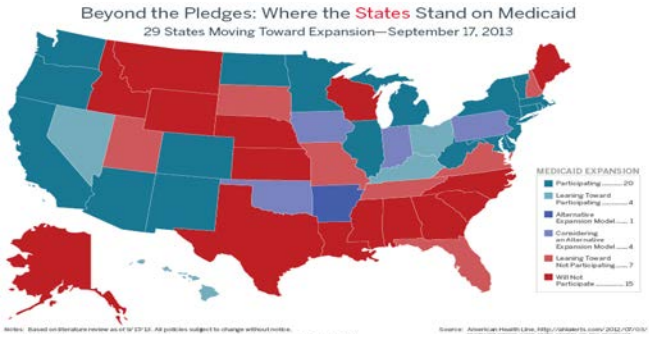
133% of the Federal Poverty Level: *What does that mean?*[ii]

= up to **$15,281 per year**
(Single person)

= up to **$25,974 per year**
(Family of 3)

CLICK THE MAP BELOW

for an integrative map and learn about your State's Medicaid Expansion program.



State Health Insurance Exchanges[iii]

How you'll get insurance if you aren't covered by your employer.

Beginning OCTOBER 1ST states will begin offering qualified health insurance plans to residents through "Marketplaces" (online shopping websites, think Kayak, or Amazon.com). Once individuals enroll, they will begin to RECEIVE COVERAGE BY JANUARY 1 OR APRIL 1, 2014, depending on when they enroll.

What Health Plans MUST Cover

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Find Your State's Health Exchange[iv]

California Colorado Connecticut
District of Columbia
Hawaii Idaho
Kentucky Maryland
Massachusetts Minnesota
Nevada NEW MEXICO
New York OREGON
Rhode Island Utah
Vermont Washington

Don't see your state?
Some states are creating **PARTNERSHIP MARKETPLACES** where they will tailor the Federal Exchange Marketplace to their needs:
Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, West Virginia

All other states will participate in the FEDERAL EXCHANGE MARKETPLACE

Individual Mandate[v]

People who do not currently have insurance through their employer, Medicaid, Medicare, or Veterans Affairs programs are required by law to purchase insurance through the State or Federal Exchanges. Those who do not will have to pay a PENALTY.

Penalty = 1% of your income or $95
(whichever is greater**)**
The penalty increases every year.

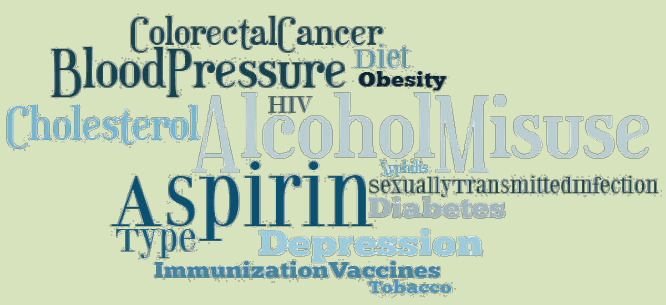
Who is affected?

All adults[vi] must purchase insurance for themselves and their families. Women[vii] receive expanded coverage, maternity benefits, and no-cost preventive services. Children[viii] up to age 26 can stay on their parents' health plans and extends funding for the Children's Health Insurance Program (CHIP) until 2015. Illegal immigrants[ix] are not eligible for the Medicaid expansion or Exchanges. Low income communities[x] will benefit from $11 billion given to Community Health Centers to improve and expand services. Employers[xi] with 50 or more employees will be required to provide insurance.

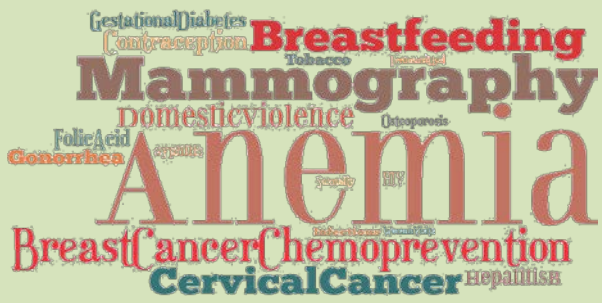
Preventive Services Covered Under the ACA[xii]

Screenings, tests, exams and treatments may depend on age, sex, or risk status.

Adults



Women



Children

RESOURCES

[i] Kaiser Family Foundation. "Focus on Health Reform: Summary of the Affordable Care Act" [ii] Medicaid 2013 Poverty Guidelines [iii] Obamacare Facts: Dispelling the Myths. ObamaCare: Health Insurance Exchange [iv] Centers for Medicare & Medicaid Services. State Health Insurance Marketplaces [v] Kaiser Family Foundation: "The Requirement to Buy Coverage Under the Affordable Care Act" [vi] The Kaiser Family Foundation. "The YouToons Get Ready for Obamacare" [vii] The Kaiser Family Foundation. "Women's Health Insurance Coverage: Fact Sheet" [viii] Whitehouse.gov/healthreform. "Health Reform for Children" [ix] U.S. Department of Health & Human Services. "The Affordable Care Act: Coverage Implications and Issues for Immigrant Families" [x] Health Resources and Service Administration. "The Affordable Care Act and Health Centers" [xi] The Kaiser Family Foundation. "Employer Responsibility Under the ACA" [xii] Health and Human Services Agency. Preventive Services Covered Under the Affordable Care Act.

A RESOURCE GUIDE PRODUCED BY
THE NATIONAL FAMILY JUSTICE CENTER ALLIANCE
FAMILYJUSTICECENTER.COM

The Affordable Care Act & Covered CA: Resources for FJCs

Overview

- Covered California: Overview
- Education & Outreach Grantees: Resources for FJCs
- Community Health Centers
- Certified Enrollment Entities/Counselors Application
- Covered CA Facebook: FAQs

Covered California: Overview

California was the first state to create a health benefit exchange following the passage of the ACA. Covered CA is charged with creating a new insurance marketplace in which individuals and small businesses can get access to health insurance. These “marketplaces” are websites where individuals and businesses can shop for different insurance plans (think Kayak.com). Covered CA has provided grants to community-based organizations to perform education and outreach for the ACA and Covered CA. In addition, organizations with access to underserved populations can become certified as Enrollment Entities and help enroll individuals in health care insurance plans.

https://www.coveredca.com/about/index.html

Education & Outreach Grantees

- Provide education and information at community events/fairs.
- Attend organization-hosted events.
- Train organization staff/volunteers on Covered CA.
- Connect organizations to Enrollment Counselors.

AHMC Health Foundation

(Alhambra Hospital Medical Center)

- Statewide
- Provide outreach and education at events.
- Do not provide training to staff.

Contact: Debbie Lin

626-312-2280

Debbie.lin@ahmchealth.com

AHMC Foundation Affiliated Hospitals

Ask for a Certified Covered CA Educator

AHMC Health Foundation Contacts
Debbie Lin or Amber Phung
(626)312-2280

Alhambra Hospital Medical Center
100 S. Raymond Avenue
Alhambra, CA 91801
(626) 570-1606

Anaheim Regional Medical Center
1111 West. LA Palma Ave
Anaheim, CA 92801
(714) 774-1450

Garfield Medical Center
525 N. Garfield Ave.
Monterey Park , CA 91754
626-573-2222

Greater El Monte Community Hospital
1701 S. El Monte
South El Monte, CA 91733
(626) 579-7777

Monterey Park Hospital
900 S. Atlantic Blvd.
Monterey Park , CA 91754
(626) 570-9000

San Gabriel Valley Medical Center
438 W. Las Tunas Drive
San Gabriel, CA 91776
(626) 289-5454

Whittier Hospital Medical Center
9080 Colima Rd.
Whittier, CA 90605
(562) 945-3561

Planned Parenthood Mar Monte

- 22 Planned Parenthood clinics throughout Northern CA provide Enrollment assistance.
- 12 part-time Educators available for events.
- Educators provide staff trainings (min 20 attendees).

Contact:

Cathy Schultz, Covered CA Program Manager

916-325-1708

Cathy_shultz@ppmarmonte.org

Planned Parenthood Mar Monte Health Centers

Certified Enrollment Counselors

Alameda County
Hayward
West Oakland 510-300-3800

Fresno County
Families First 559-446-1515
Fulton 559-488-4900

Kern County
Bakersfield

Merced County
Merced 209-723-7751

Monterey County
Salinas 831-758-8261

Sacramento
B Street 916-446-6921
Fruitridge 916-452-7305

San Joaquin County
Eastland Plaza 209-466-2081
Tracy 209-835-8910
North Stockton 209-477-4103

San Mateo
San Mateo

Santa Clara County
San Jose 408-287-7526
Gilroy 408-847-1739
Eastside 408-729-7600
Mar Monte 408-274-7100
Mountain View 650-948-0807
Blossom Hill 408-281-9777

Santa Cruz County
Watsonville 831-426-5550
Westside 831-426-5550

Stanislaus County
Modesto 209-579-2300

California Black Health Network

- Coordinates 11 subcontracting sites from Sacramento to San Diego
- Certified Educators can attend events.
- Can send Enrollment counselors to events as well.

Contact:

Cynthia Kennedy, Project Manager

916-591-6170

ckennedy@calblackhealthnetwork.org

San Diego LGBT Community Center

- Can provide trainings to staff/volunteers (9 hours for Certified Educator training).
- Can attend events.
- Can connect to other California LGBT organizations.

Contact:

Denise Serrano

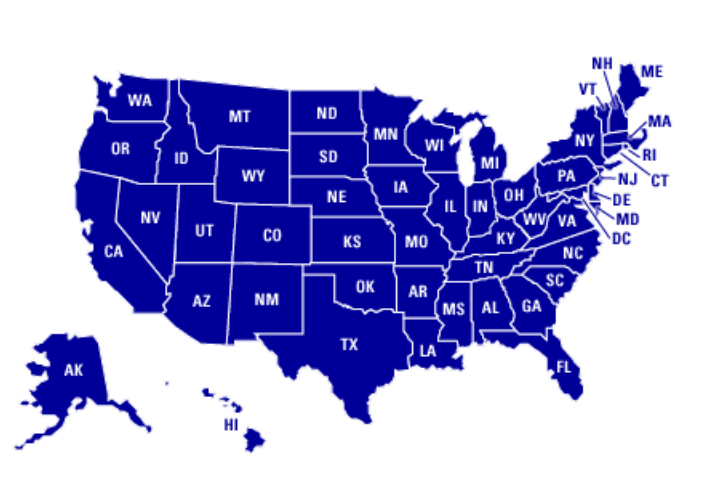
619-692-2007 x103

dserrano@thecenter.org

Community Health Centers

- $150 million in grants awarded to 1,159 health centers across the country to provide education and enrollment assistance.

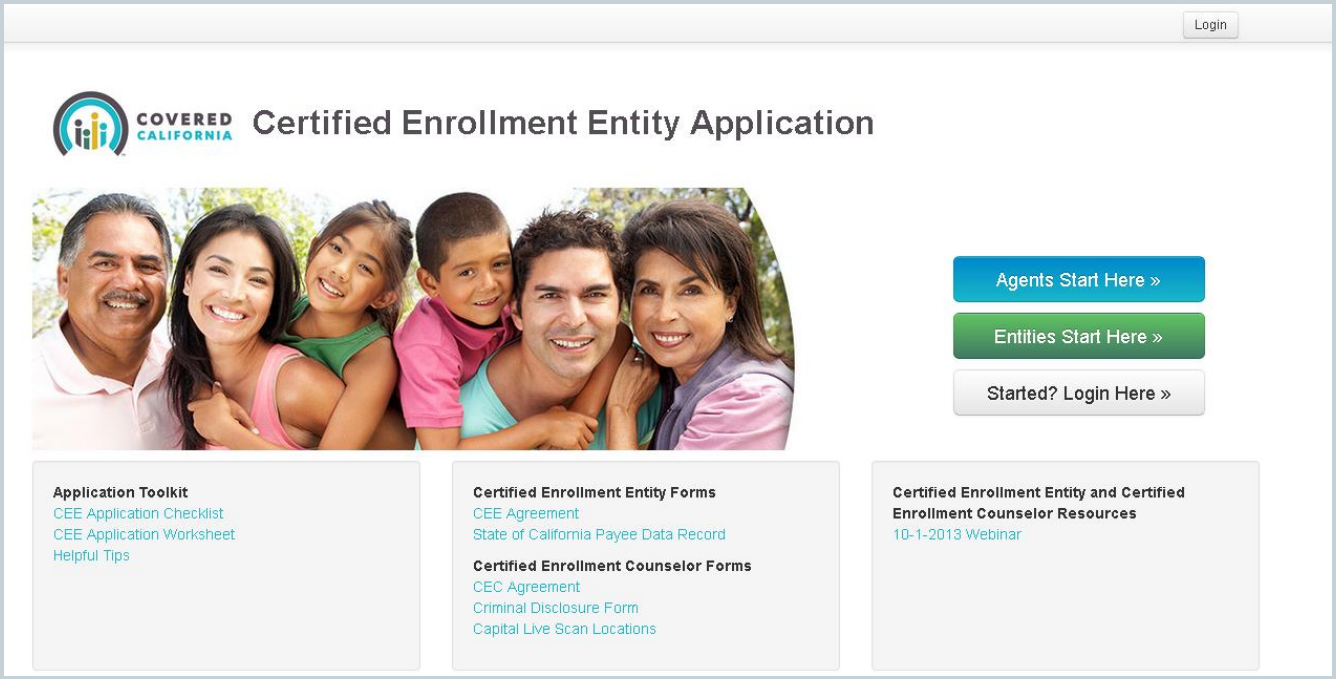
Find a center in your state/region:



Certified Enrollment Entities/Counselors

- Organizations can apply to be an Enrollment Entitiy.
- Staff/volunteers can apply to be an Enrollment Counselor under that Entity.
- Enrollment Entities receive free training from the State.
- Enrollment Entities can be compensated for each successful enrollee in Covered CA:
  - $58 for each initial application during open or special enrollment
  - $58 for each re-enrollment application
  - $25 for each annual renewal application

Application Site



Covered CA on Facebook: FAQs

National Family Justice Center Alliance

Webinar Training

Part II The Solutions: Integrating Health Assessments into Domestic Violence Programs

Presented by Virginia Duplessis, Ruth Micklem, Mercedes Hill, Anna Williams & Sara Wee

February 19, 2014

Certificate of Attendance

1.5 Hours

Gael Strack, JD
Co-Founder and CEO
Family Justice Center Alliance

Natalia Aguirre
Director of Technical Assistance
Family Justice Center Alliance

Date of Issue: January 29, 2014