COBTH

CONFERENCE OF BOSTON TEACHING HOSPITALS

Best Practices in Healthcare and Domestic Violence

Lessons Learned in Boston

Conference of Boston Teaching Hospitals Domestic Violence Council
February 2018

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On behalf of the Conference of Boston Teaching Hospitals (COBTH) and its member institutions, I am pleased to share this updated version of *Best Practices in Healthcare and Domestic Violence: Lessons Learned in Boston,* Second Edition, 2017.

Formed more than twenty-five years ago, COBTH is an organization of twelve Boston-area teaching hospitals that work together to advance policies which enable them to fulfill their missions of medical education, research, providing high quality care and serving vulnerable populations. In the otherwise highly competitive healthcare environment, COBTH provides a forum for hospitals to work together on the common goals and issues facing the communities and patients they serve.

In 1995, COBTH convened a Domestic Violence Task Force to fully engage in addressing the issue of domestic violence in Boston. As a result of the Task Force, the Domestic Violence Council (DVC) was formed to provide leadership and inform each hospital's interventions with patients, employees, and community members facing domestic violence. For twenty years the DVC has sustained active, vibrant partnerships among hospitals, community health centers, domestic violence and rape crisis programs, state agencies and local constituents who are all committed to ending interpersonal violence in all forms.

While COBTH members are teaching hospitals and academic medical centers located primarily in urban settings, it is hoped that the lessons and examples presented here can be applied in any number of healthcare settings. From the community hospital looking to expand its existing program, to the rural health center considering developing a new program, this manual is a resource that can enrich the dialogue among domestic and sexual violence programs, healthcare providers, and other interested parties committed to strengthening domestic violence responses within healthcare settings.

John Erwin
Executive Director
Conference of Boston Teaching Hospitals

1 - Introduction

a. Background

In 1995, the Conference of Boston Teaching Hospitals (COBTH) convened a Domestic Violence Task Force at the urging of the Mayor of Boston and the Suffolk County District Attorney. The academic medical centers and hospitals were compelled to fully engage in addressing the issue of domestic violence in Boston. As a result of the Task Force, the Domestic Violence Council (DVC) was formed to provide leadership and inform each hospital's interventions with patients, employees and community members facing domestic violence. Since then, the DVC has sustained active, vibrant partnerships among hospitals, community health centers, domestic violence and rape crisis programs, state agencies and local constituents who are all committed to ending interpersonal violence in all forms. The DVC has become as a leader locally and nationally. The DVC has an ongoing commitment to share resources and knowledge in order to advance the response to domestic violence within healthcare.

b. Purpose

The idea for this document was conceived because the DVC receives frequent requests for information, technical assistance, and strategic planning support from its own DVC members, healthcare providers, domestic violence organizations and many others locally, across the country and internationally. This online manual is intended as a resource to share "best practices" and current thinking among the DVC members. Its primary goal is to enrich the dialogue among programs, healthcare providers, domestic and sexual violence program experts, and other interested parties committed to strengthening domestic violence responses within healthcare settings. It is a place to share questions, "tried and true answers," and successful approaches to this complex work in healthcare. The subtitle of the document is "Lessons Learned in Boston," but perhaps more accurately we might add, "Lessons We Are Still Learning in Boston." Domestic violence programming in healthcare is a dynamic field. We continue to learn about better ways to improve the healthcare responses to domestic violence. This document contains some of the key issues we are discussing, and is a place to hold shared information. In this second draft edition, we have updated information and broadened the scope to respond to colleagues working in a variety of healthcare settings -- beyond academic medical centers.

Terms Used in This Document

For brevity, we refer to domestic and sexual violence programs based in Boston-area healthcare organizations as ***"DVC member programs"*** or "DVC programs"

We refer to advocates working in sexual and domestic violence programs as "***Program Advocates***" or "***Program Staff***".

c. Acknowledgements

A "Best Practices" Working Group provided leadership in developing this project. Working Group members compiled materials, discussed and conceptualized the information to be included, and wrote sections of the manual. Working Group members include Debra Drumm, MSW, LICSW, Director of HAVEN at Massachusetts General Hospital, Jonna Green, MSW, LCSW, Program Coordinator at AWAKE at Children's Hospital, Merle Kushner, MSW, LICSW, Lahey Clinic, Lisa LaChance MSW, LICSW, Director of the Center for Violence Prevention and Recovery at Beth Israel Deaconess Medical Center, Lorraine Lafata, MSW, LICSW, Clinical Director, Community Advocacy Program of CCHERS, Melanie LeGeros, MSW, LICSW, past Program Coordinator, Passageway at Brigham and Women's/Faulkner Hospitals, Erin Miller, MPS, MDV, CTSS, CASAC-T, Program Manager at Newton-Wellesley Hospital, Liz Speakman, MSW, LICSW, past Director of HAVEN at Massachusetts General Hospital, and Joanne Timmons, MPH, Domestic Violence Program Manager at Boston Medical Center. Tina Nappi, MSW, LICSW, formerly the Director at Passageway, served as a consultant to the group by facilitating working group discussions and a focus group session, and by organizing, writing and editing materials in this document.

In addition to the Working Group members, additional DVC members generously shared their time and ideas by participating in a focus group session, and/or in follow-up conversations for the first and second versions of this document. They include: Sue Chandler, MSW, MPH, Executive Director at DOVE, Inc. and former Director of the Community Advocacy Program; Mardi Chadwick, JD, Director of Violence Intervention Programs, Brigham and Women's Hospital; Carolyn Foster, Program Manager at the Boston Area Rape Crisis Center; Katia Santiago-Taylor at the Boston Area Rape Crisis Center, Jackie Savage Borne, MSW, LICSW Hospital Program Manager at Passageway; and Bonnie Zimmer, MSW, LICSW, former Director of HAVEN at MGH.

2 - COBTH Domestic Violence Council

a. Core Values and Current Membership

The Conference of Boston Teaching Hospitals (COBTH) has provided a conduit for partnership among the Boston-area healthcare organizations through the Domestic Violence Council (DVC). Consistent with the values of the movements to end violence, the DVC members acknowledge that the most successful interventions and prevention efforts require dedicated collaboration among a variety of organizations and communities.

The DVC members understand that a clear vision for ending violence against women and all forms of gender-based violence requires a broader analysis of oppression in our society. Structural inequality and racism in the United States is rooted in violence against racial and ethnic minorities. This creates additional barriers for some survivors of sexual and domestic violence to access assistance and protections. Understanding and respecting the experiences of survivors in diverse communities is integral to effectively addressing sexual and domestic violence. This includes working with historically underserved and marginalized populations: people of color, immigrants, GLBTQ people, elders, and people with disabilities.

Even the most well-intended interventions can be re-traumatizing and re-victimizing to survivors. The members of the DVC strive to be inclusive and aware of the power dynamics that create barriers to assistance for survivors of violence. The DVC members share a fervent commitment to providing trauma-informed and culturally appropriate care. They are invested in creating and supporting environments where diverse life experiences and identities are affirmed, welcomed, and celebrated.

Individually and collectively, the DVC members bring more than 25 years of experience developing healthcare responses to domestic violence, and some have experience in responding to sexual assault for just as long. The DVC has convened consistent monthly meetings since its inception in 1995. Meetings are well attended and full of candid, lively discussions about challenging issues. The membership includes domestic violence and sexual violence leaders from hospitals, community health centers, city, state and non-profit organizations (current DVC membership list).

The DVC is enriched by the legacy and creativity of effective domestic violence and sexual assault programs throughout Boston and the Commonwealth of Massachusetts. It is important to acknowledge that many partnerships and collaborations have enhanced the capacity of Boston's healthcare responses to domestic violence. John Erwin, Executive Director of COBTH, presented the work of the DVC at a past National Healthcare and Domestic Violence conference (presentation).

b. Timeline of Accomplishments

The COBTH Domestic Violence Council membership includes domestic violence and sexual violence leaders from hospitals, community health centers, city and state agencies, and non-profit organizations.

In 2004, the COBTH DVC members created a timeline to highlight the accomplishments in domestic violence and healthcare responses in the Boston area.

Year	Accomplishment
1986	• Boston Children's Hospital launched the Advocacy for Women and Kids in Emergencies (AWAKE) Project, the first advocacy program for women in a pediatric healthcare setting • Victims of Violence Program created at Cambridge Hospital (now Cambridge Health Alliance)
1992	• Boston Public Health Commission developed its Domestic Violence Program Child Witness to Violence Project founded at Boston Medical Center • DV Initiative at Lahey Clinic (now Lahey Hospital & Medical Center)
1993	• Domestic Violence Institute at Northeastern University
1994	• Safe Transitions DV program created at Beth Israel Deaconess Medical Center, now, the Center for Violence Prevention and Recovery, addressing DV, sexual assault, community violence and homicide bereavement
1995	• Suffolk County District Attorney, Boston Police Commissioner, Boston Mayor's Office ask COBTH CEOs for more involvement with DV • COBTH convened Domestic Violence Task Force, today known as the Domestic Violence Council • Community Advocacy Program (CAP) created at CCHERS, Inc.
1996	• DV Task Force created at Caritas St. Elizabeth's Medical Center DV Task Force released recommendations
1997	• COBTH held Train the Trainer session on DV for over 100 staff from area hospitals and health centers • HAVEN (DV program) created at Massachusetts General Hospital • Passageway (DV program) created at Brigham and Women's Hospital • COBTH presented to the Association of American Medical Colleges Government Relations and Public Affairs Council
1998	• Public awareness event "Celebrating Survival" at Harvard Medical School
1999	• Department of Justice funded Hospital-Legal Collaboration Project with Greater Boston Legal Services and COBTH hospitals • DV Council members were key in initiation of Stop Abuse Gain Empowerment (SAGE) – Boston Collaborative to address abuse of older women and partner abuse in later life
2000	• COBTH presented at the National Healthcare and Domestic Violence Conference
2001	• DV Council members participated in SHARED Project and National Standards of Family Violence Prevention Fund (now Futures Without Violence) • COBTH working group created to develop outcome measures for domestic violence programs
2003	• AHRQ funded proposal "Validation of a Domestic Violence Program Impact Measure" with COBTH and Harvard School of Public Health
2004	• DV Council members appointed to the Massachusetts Governor's Commission on Domestic and Sexual Violence
2005	• Passageway at Brigham and Women's Hospital launched legal service partnership: The Passageway Health Law Collaborative with Harvard Law School's Legal Service Center
Year	**Accomplishment**

Year	Accomplishment
2007	• Boston Medical Center launched its Domestic Violence Program
2008	• Newton-Wellesley Hospital launched its Domestic Violence/Sexual Assault Program • Massachusetts Department of Public Health declared a Public Health Advisory on Domestic Violence
2010	• COBTH hosted Partnering Youth and Healthcare to Prevent Teen Dating Violence
2013	• COBTH sponsored "Keeping Survivors at the Center: How Health Reform Will Impact Intimate Partner and Sexual Violence Response Systems in Massachusetts"
2014	• Massachusetts Department of Public Health issues a Circular Letter to Hospitals on Domestic and Sexual Violence • Massachusetts Legislature signed new Domestic Violence Bill, Chapter 260 into law, which mandated training of healthcare providers as a condition of licensure
2015	• DV Council members participated in Massachusetts Rural Domestic and Sexual Violence Project hosts a summit "Caring for Survivors: Strengthening Collaborations Between Healthcare and Domestic/Sexual Violence." • Massachusetts Medical Society published its 6th edition of Intimate Partner Violence: A Clinician's Guide to Identification, Assessment, Intervention and Prevention by Dr. Elaine Alpert.

c. Technical Assistance Role of COBTH DVC

The DVC members provide information, technical assistance and strategic planning support on a myriad of programmatic issues, many of which are mentioned in this document. DVC members have met with personnel from healthcare organizations in Massachusetts, across the United States and internationally. A survey link is available to request further information and/or technical assistance from the DVC.

d. Program Models within Boston/DVC Member Programs

Several of the DVC members are directors and staff of healthcare based domestic and sexual violence programs. Throughout the remainder of this document, the terms "*DVC member programs*" or "*DVC programs*" will be used to refer to these healthcare based programs. A list of the DVC programs is included in the appendix of this document.

The structures of the DVC member programs vary, and depend somewhat on the organizational structures of their individual healthcare organizations. The programs in the Greater Boston area are situated in large academic medical centers, community hospitals, pediatric hospitals, veterans' medical services and community health centers.

Within their respective healthcare settings, the DVC member programs are positioned in a variety of departments. Program development has been intentional to ensure that the mission of the domestic violence program is strategically aligned with and contributes to the healthcare organization's mission. It has been critical to locate a program within a department or division that has access to senior leadership and key decision-makers, provides consistent support and creates opportunities for program growth and development. As examples, DVC programs are part

of Departments of Nursing, Care Management, Community Benefits, Quality and Safety, Health Equity and Social Work.

e. Program Models throughout Massachusetts

Throughout Massachusetts, a variety of models of domestic violence and sexual assault programming in healthcare settings are highly effective and reflect the needs of the specific community.

The following examples reflect the diversity of responses within Massachusetts:

- North Shore Medical Center, outside of Boston, supports CrossRoads, a comprehensive advocacy services program of a community-based domestic violence program that is co-located within the healthcare setting.
- In northeastern Massachusetts, the city of Lawrence's Mayor's Taskforce integrates a public health approach to community wellness that includes domestic and sexual violence prevention through the YWCA of Greater Lawrence's domestic violence program. Recently recognized as 2015 Robert Wood Johnson Foundation Culture of Health Prize winner, the Lawrence's model includes women's health outreach as an integrated component of advocacy services for survivors.
- In the rural communities in western Massachusetts, the Hilltown Safety at Home Program of the Hilltown Health Centers employs a domestic violence advocate who works in collaboration with Safe Passages, a domestic violence organization. The Hilltown Advocate's outreach component is extensive in that she serves the needs of survivors who are isolated in rural communities and often without transportation to access services.

a. Advice to New Programs

The COBTH DVC Best Practices Working Group convened a focus group with directors of domestic violence and sexual assault programs to ask them to share the most important piece of advice they would give to new programs as they start their work in a healthcare organization. The following summarizes the advice to new programs:

1. Align your program with the mission of the healthcare organization as much as you can. Be clear, concrete, and vocal about this. For example, the programs' goals may resonate with the organization's mission statement that includes language such as "serve the community", "provide compassionate care", "provide exceptional care" and/or "train the future leaders of healthcare."
2. Understand your institution's history in providing domestic violence responses – before the DV program was conceived.
    1. Who "owns" or is responsible for the issue in the healthcare institution?
    2. What are the formal policies and protocols?
    3. What are the informal practices?
3. Define abuse and the types of violence you will address. Be clear and intentional about the scope of your program.
    1. Who will you serve?
    2. Do you have the capacity to respond?
    3. What resources do you need?
4. Identify champions and allies within the healthcare organization to help you navigate the hospital/health center and to support the development, structure, operations, and needs of your program.
    a) Scan the environment. Get to know the healthcare organization. Attend meetings, forums and events in order to learn about the organization and to get a sense of operations.
    b) Focus on finding the people within the healthcare organization who have the investment, capacity and resources to work with you and your program.
    c) Identify internal leaders who are decision-makers and can support your program in the long-term, not just as you launch the new program.
    d) Identify champions within each discipline and department.
    e) Know your allies and expect friction/conflicts in some areas.

5. Be prepared to find unexpected allies in many disciplines and departments within the healthcare organization. There are numerous people who are invested in helping, some of whom may already be involved in some way; others of whom may not know how to get involved.
6. Analyze the opportunities. Review every discipline and department in your institution. Understand their current practices in responding to violence, as well as their written protocols/policies. Evaluate the key players/areas, including but not limited to:

    - Senior Leadership/Administration
    - Physicians
    - Nurses
    - Social Workers
    - Security
    - Human Resources
    - Employee Assistance Services

- Child Protection Team/Elder Abuse Intervention Team if available
- Additions and Mental Health Specialists
- Institutional Review Boards (IRBs) and Research Development
- Fundraising/Development
- Community Health
- Education and Training Departments/Personnel
- Affiliated satellite sites, outpatient clinics, and private practices

7. Strategically locate the program in the division or department where you feel you will get the most support and visibility while creating a private and safe space for survivors and staff. The physical location matters.

b. Aligning the Work with Healthcare Setting's Mission

In order to be effective, a hospital's internal domestic and/or sexual violence (DV/SA) program's goals and objectives should be closely tied to those of the larger institution. The more fully these shared goals can be articulated and demonstrated, the better. The program director and staff should become well versed in describing and giving examples of how the DV/SA program efforts support and contribute to the overall goals and mission of the hospital/health center. The program should assist others who speak on behalf of the institution, such as Development, Corporate Communications, etc. in doing the same. The goal is for the program to be viewed as a critical and supporting piece of a larger mission, rather than as an add-on or unrelated effort. This will encourage healthcare professionals to become involved and participate in the program's efforts.

Organizational Assessment

Before the launch of the program within the healthcare organization, conduct a formal assessment of the organizational policies and practices related to domestic and sexual violence. The Agency for Healthcare Research and Quality (AHRQ) developed a consensus-driven quality assessment tool for evaluation of hospital-based domestic violence programs. Jeffery H. Coben, M.D., AHRQ Domestic Violence Senior Scholar-in-Residence[1], based the instrument on the views of 18 national experts who took part in an AHRQ-funded Delphi process. The DVC member programs have found this tool, The Delphi Instrument, effective in conducting baseline and periodic assessment of their healthcare organizations.

The tool can be accessed here. The Delphi Instrument assesses the following aspects of the organization:

1. Hospital Policies and Procedures
2. Hospital Physical Environment
3. Hospital Cultural Environment
4. Training of Providers
5. Screening and Safety Assessment
6. Documentation
7. Intervention Services
8. Evaluation Activities
9. Collaboration

[1] Coben J. Measuring the quality of hospital-based domestic violence programs. *Academic Emergency Medicine* 2002; 9(11):1176-1183.

One modification to the tool would be to add the concept of "Universal Education" to section 5 above, "Screening and Safety Assessment" so that healthcare providers are not limiting their perspective. The goal of screening is to open the door for individuals to know that healthcare is a resource for support.

Dr. Coben's work was adapted by Dr. Therese Zink for use in primary care settings.

Sustainability

Some of the COBTH DVC Member programs have experienced staffing cuts and programmatic disruptions within their respective healthcare organizations due to loss of funding, leadership changes and competing priorities. Having to rebuild a domestic or sexual violence program is challenging. We welcome talking with anyone in this situation to share our specific experiences and strategies. Contact us via the survey link.

From our experiences, we have learned that the following are helpful to successful program sustainability within the healthcare setting:

- Well-defined statement of how the program aligns with the mission of the organization;
- Clear program scope and well articulated intersection with other forms of abuse and violence that may be present within the organization itself;
- Placement of the program within a department or division of the healthcare setting that has regular access to senior management;
- Active and strategic leadership team or advisory committee for the program;
- Active and leadership role in training healthcare providers;
- Frequent visibility of the program within internal and external organization publications, employee newsletters, and awareness events;
- Staff participation and contribution to healthcare setting committees, such as planning Patient Family-Advisory Councils, Institutional Review Boards, Child Protection Teams, and Employee Health and Wellness Committees.

c. Creating Internal Leadership/Advisory Committees

COBTH DVC member programs have invested significant time in forming leadership teams within their respective healthcare organizations to advance system-wide responses to domestic and sexual violence. These teams strategically invite healthcare professionals to serve as advisors and ambassadors for the programs. Invited professionals are decision-makers in their respective clinical or administrative areas. They represent a wide variety of departments and clinical areas. While some are invited because they already have an understanding and investment in responses to domestic/sexual violence, many bring additional perspectives and approaches which can enhance the work.

A variety of iterations of leadership/advisory groups exist in DVC member programs. Some common considerations and recommendations include:

- Articulate and reinforce statements of purpose and goals for the leadership team.
- Invite members who can work strategically toward team's goal, rather than keeping the team open-ended or having people volunteer to participate.
- Utilize purposeful, clear and efficient meeting agendas when convening the leadership/advisory.

- Meetings should highlight action plans and mechanisms for advising the work, engaging activities and supporting system-wide responses to domestic and sexual violence. Be broad, not detail-minded, when discussing program updates.
- Reach out to healthcare administrators and clinical leaders who are experts and decision-makers in their respective areas, yet may know less about violence.
- Invest in a community advisory council/leadership team, comprised of community members and stakeholders, to gain invaluable perspectives outside the healthcare setting.
- Build relationships and increase accountability to ensure the work of the program is aligned with the needs of the community.

The following table provides information about the leadership teams within 7 healthcare-based domestic violence and sexual assault programs. The teams have similar purposes and goals. They may differ in members, agendas and frequency of meetings.

Institution **Name of Leadership Team**	**a. Purpose/Goals** **b. Typical Agenda**	**Members** **Leadership from….**	**Frequency**	**Facilitator**
Beth Israel Deaconess Medical Center **Domestic Violence Advisory Council**	a. Originally created to implement the DV program. Now, the group provides strategic planning, guidance and support to the program. Key stakeholders come together to discuss how the hospital can best address the issue of domestic violence. b. Agenda is focused on specific issues, review of accomplishments, action-items and plan for next meeting. Agenda includes a presentation by an internal or external (community) partner.	• Hospital Chaplain • Director of Social Work • Security/Public Safety • OB Social worker • E.D./Trauma Social Worker • Employee Assistance • Human Resources • Physician/Nurses trainings • Health Quality	Quarterly --frequency to be determined when group resumes	Director of the Center for Violence Prevention and Recovery
Medical Advocacy Program **Boston Area Rape Crisis Center** **Advisory Committee** **for Forensic Project**	a. Cross-discipline education; Create informational resource; Review protocols and create best practices b. Agenda is educational and goal-oriented.	• Suffolk County District Attorney • Boston Police • Sexual Assault Unit • Boston Crime Lab • State Crime Lab • Forensic Liaison • MA State Executive Office of Public Safety	Quarterly	Medical Advocacy Program – Program Manager

Institution **Name of Leadership Team**	**a. Purpose/Goals** **b. Typical Agenda**	**Members** **Leadership from….**	**Frequency**	**Facilitator**
Boston Medical Center **Domestic Violence** **Advisory Committee**	a. Originally created to implement the DV program. Now, the group provides strategic planning, guidance and support to the program. Key stakeholders come together to discuss how the hospital can best address the issue of domestic violence. b. Agenda is focused on specific issues, review of accomplishments, action items and plan for next meeting. Agenda includes a presentation by an internal or external (community) partner.	• Nurses • Public Safety • Human Resources • General Counsel • Social Workers from different clinical areas • Interpreter Services • Child Witness to Violence Project • Child Protection Team • Violence Intervention Advocacy Program • Community Violence Response Team • Pastoral Care • Behavioral Health • BU Medical School • Patient Advocacy • Boston Area Rape Crisis Center	Bi-Annual	Domestic Violence Program Manager

Institution **Name of Leadership Team**	**a. Purpose/Goals** **b. Typical Agenda**	**Members** **Leadership from….**	**Frequency**	**Facilitator**
Brigham and Women's Hospital **Domestic Violence** **Steering Committee**	a. Increase the visibility of domestic violence throughout the hospital; brainstorm about gaps/needs b. Review of accomplishments; planning for upcoming events/issues	• Social work (co-chair) • CCHHE Executive Director (co-chair) • Emergency Department • OB/GYN • Security • Psychiatry • Nursing Education • Chaplaincy • Human Resources • Directors from the CCHHE • Trauma Division • Employee Assistance Program	Quarterly	Passageway Director
Massachusetts General Hospital **Domestic Violence** **Steering Committee**	a. Strategic planning; Stakeholders coming together to provide support to the DV program and build institutional leadership on DV issues. b. Review accomplishments; seek input/guidance on specific issue and projects	• Security • Employee Assistance Program • Chaplaincy • Social Work • Director of Admitting • OB/GYN • Administration/ Medical Directors from Health Centers • Chief Financial Officer from the MGH Physicians' Organization	Annually	Director of OB/GYN and HAVEN Director

Institution **Name of Leadership Team**	**a. Purpose/Goals** **b. Typical Agenda**	**Members** **Leadership from….**	**Frequency**	**Facilitator**
Newton-Wellesley Hospital Domestic Violence Steering Committee	a. Strategic planning, guidance and support to the program. Key hospital stakeholders come together to discuss how the hospital can best address the issue of domestic violence. b. Agenda is focused on specific issues, review of accomplishments, action-items and plan for next meeting.	• OB/GYN • Nursing Leadership • Human Resources • Social Work • Employee Assistance • Human Resources • Security • Geriatrics • Pediatrics • Community Benefits • Emergency Medicine • Development • Ambulatory Services • Psychiatry	Bi-annual	Domestic Violence/ Sexual Assault Program Coordinator
Newton-Wellesley Hospital Domestic Violence**/Sexual Assault Program** Advisory Committee	a. Strategic planning, guidance and support to the program. Key community stakeholders come together to discuss how the hospital can best address the issue of domestic violence b. Agenda is focused on specific issues, review of accomplishments, action-items and plan for next meeting.	• Boston Area Rape Crisis Center • Local Shelters/Community-based DV Programs (3) • Massachusetts Department of Children and Families • Massachusetts Office of Victim Assistance • Community Activists • Survivors (2)	Bi-annual	DV/SA Program Coordinator

d. State Laws and Policies

To develop effective programs, it is important to understand the relevant laws and policies that may impact survivors of violence and the operations of the program. Some helpful questions to consider include:

- What are the state and national laws pertaining to domestic violence and sexual assault, both criminal and civil?
- What do the state mandated reporting laws require/involve?
- What are the other relevant state laws pertaining to discrimination, immigration, interpreter services, emergency contraception, mature minors and medical care, etc.?
- How do the police, courts, and other systems handle abuse cases?
- What constitutes victim/survivor service provider privilege?
- Who are the community partners (e.g., DV shelters), what are their respective capacities, policies, referral processes, etc.?
- Is there a Sexual Assault Nurse Examiner's (SANE) or other forensic service program and/or Children's Advocacy Centers? If so, what are their protocols, and where are their sites?

Specific to Massachusetts, the Commonwealth issued a circular letter in November 2014 to hospitals with two recommendations about healthcare responses to domestic and sexual violence. These recommendations support hospitals and healthcare organizations in addressing domestic and sexual violence and advocate for survivor-centered responses in collaboration with community based organizations.

The Circular Letter DHCQ 14-11-622 specifically recommends that healthcare settings:

1. *"Develop partnerships with community-based organizations that specialize in providing trauma-informed, post-acute services that address the complex needs of victims of domestic and sexual violence, and their families."*
2. *"Utilize best practices and trauma-informed approaches in the hospital when responding to victims of domestic and sexual violence."*

Also, Massachusetts Law, Chapter 260 of the Acts of 2014 mandates training for providers as a condition of statewide licensure. The law states:

> *"The board of registration in medicine, the board of registration in nursing, the board of registration of physician assistants, the board of nursing home administrators, the board of registration of social workers, the board of registration of psychologists and the board of registration of allied mental health and human services professions shall develop and administer standards for licensure, registration or certification pursuant to this chapter, as applicable, and any renewal thereof, that require training and education on the issue of domestic violence and sexual violence, including, but not limited to, the common physiological and psychological symptoms of domestic violence and sexual violence, the physiological and psychological effects of domestic violence and sexual violence on victims, including children who witness such abuse, the challenges of domestic violence and sexual violence victims who are gay, lesbian, bisexual, transgender, low-income, minority, immigrant or non-English speaking , availability of rape and sexual assault shelter and support services within the commonwealth. Training shall also address the pathology of offenders including, but not limited to, identifying the system of abusive behaviors used to maintain control, the intentionality of the violence, the tendency to minimize abuse and blame the victim and the risk to the victim created by joint counseling. Each board may work with community-based domestic violence, rape and sexual assault service providers*

and certified batterer's intervention programs in order to develop the standards required by this section."

The Massachusetts Chapter 260 requirement creates a significant opportunity for domestic/sexual violence programs in healthcare settings and the community to connect with those responsible for maintaining the licensure for healthcare providers. Programs can take the initiative in leading these trainings and/or offer information about their services in the trainings mandated by the licensure requirement.

e. Professional and National Resources

Virtually every professional healthcare organization has a policy and/or practice statement on how its members should be addressing domestic and sexual violence. When developing a DV program, become familiar with organizational policy statements and best practice guidance. Such professional recommendations can have numerous implications for DV programs operating in or in partnerships with healthcare organizations.

In 2015, the Massachusetts Medical Society released its 6th edition of The Clinician's Guide to Intimate Partner Violence, which is available online. It includes detailed practice considerations and protocols for best practices for physicians and other clinical providers.

Suggested Resources

- World Health Organization
- Centers for Disease Control
- American Nurses Association
- American Association of Colleges of Nursing
- American Medical Association Policy on Family and Intimate Partner Violence
- American College of Obstetricians and Gynecologists (ACOG)

The Institute of Medicine's seminal report, *Clinical Preventive Services for Women: Closing the Gaps*, is an important document with which programs should be familiar. It recommends culturally sensitive, supportive screening and counseling for interpersonal and domestic violence for all women and adolescent girls. This recommendation was implemented in the Affordable Care Act.

As the COBTH DVC programs have developed over the years, one helpful resource has been the National Health Resource Center on Domestic Violence of Futures Without Violence. It has extensive materials online: a healthcare "toolkit", free technical assistance, and outreach and education materials and guidelines for addressing domestic violence in healthcare settings.

f. Funding Strategies

A key strategy of the programs run by the Boston DVC members has been to enable their respective healthcare organizations to "own" the issues of domestic violence and sexual assault. Because domestic violence and sexual assault is increasingly framed as a "healthcare" issue – rather than social or personal issues - many healthcare organizations are encouraged to support DVC member programs. Further support stems from the growing recognition of the negative health consequences of all forms of interpersonal violence. Investing in DV programming is investing in harm reduction and wellness and prevention strategies to mitigate the damaging health effects of violence. Inevitably, funding is a

complicated issue. Healthcare organizations do the best they can, given the realities of their budgets and competing priorities.

Some COBTH DVC member hospitals prioritize funding for their in-house domestic violence and sexual assault programs while continuing to support community-based programs. For example, a few healthcare based DV programs have made the decision not to apply for public and private funds that would compete with community-based services. In addition, when healthcare organizations seek out private or public funds, there is intentional collaboration and resource sharing with community partners. Hospitals and healthcare systems provide assistance and support to community partners in a variety of ways: sponsoring fundraising events and activities, allowing use of facilities for meeting space at no charge, providing volunteers, gift cards for shelter guests, and sometimes even furniture. As part of the healthcare organization and community partnership, some DVC member programs offer free continuing education and training sessions to community program staff members.

Lastly, the COBTH DVC group as a whole, and individual member programs use their collective power to advocate for funding for important community-based and statewide programs by writing letters of support and testifying at public hearings. In 2015, a legislative hearing about eligibility for homelessness services was well attended by COBTH members who testified on behalf of survivors' needs and support for community organizations. As state funding is procured, COBTH members are at the table with state agencies and community-based organizations to discuss how funding streams are structured to address the needs of survivors.

4 - Community Linkages

a. Collaboration Between Healthcare and Community Based Domestic Violence and Sexual Assault Programs

Community linkages are integral to effective healthcare responses to domestic violence. Community domestic violence and sexual assault program partners are valued experts in the field, who provide consultation and support to the work in the healthcare setting. Community partners provide critical survivor services such as 24-hour hotlines, shelter, support groups, counseling, legal advocacy, and other assistance methods. Without the community safety net and specialized services for sexual and domestic violence survivors, healthcare providers would not be able to adequately care for victims.

Likewise, healthcare-based domestic violence and sexual assault programs provide technical assistance and consultation to community-based providers. For example, healthcare-based domestic violence programs can help community providers navigate the healthcare system. They can assist community agencies in accessing health education information and medical expertise to assist survivors. They can provide education about the health impacts of domestic violence and sexual assault.

The following are some ways that COBTH DVC programs collaborate with community-based sexual assault and domestic violence programs:

- **Assist domestic violence survivors in accessing and navigating the healthcare system.** Community-based programs may call healthcare-based sexual assault and domestic violence (S/DV) programs to identify providers, including primary care, OB/GYN care, specialty care, mental health and addition services. When a survivor is staying at a DV shelter/safe bed and needs to access healthcare, the healthcare program can assist the community-based program and survivor with safe access to medical care.
- **Increasing safety for survivors.** Healthcare-based S/DV programs can provide consultation and education to providers about how to effectively address abuse in the delivery of medical and/or mental healthcare. When a survivor in a community-based program has safety concerns related to his/her care, healthcare programs can assist them in making connections within the healthcare setting to address these concerns.
- **Ongoing advocacy services for survivors.** Healthcare-based S/DV programs have advocates who provide ongoing support and counseling, including support groups and safety planning for individuals. Because some individuals find the environment of a healthcare organization a comfortable and safe place to receive ongoing help, community-based programs can assist in.
- **Health** referrals **education and promotion.** Healthcare S/DV programs have access to information on numerous medical conditions and health issues that may be helpful to staff and/or participants at community-based programs. The information may be shared in written materials or through an arranged workshop or presentation by a healthcare provider.
- **Networking and resource sharing for staff.** Healthcare S/DV programs often sponsor training and in-service learning forums that are open to community-based program staff.
- **Education and prevention efforts**. All healthcare programs have training components and/or provide staff/provide training. Collaboration with community programs enhances training and outreach efforts, since many survivors identified in the healthcare setting can benefit from community-based services.
- **Space for community programs.** Some of the COBTH member hospitals offer low- or no-cost space for community domestic and sexual violence organizations to run support groups, hold community and professional trainings, and/or sponsored fundraising events.
- **Systems advocacy.** DVC programs advocate for survivors by highlighting gaps in services, and working to address systematic issues with community partners. One example of this is the Emergency

Department Shelter Survey which tracks difficulties survivors face when trying to access emergency shelters. The survey is administered by social workers and program advocates in Emergency Departments within the DVC member hospitals and the results are used to educate policymakers and funders about a critical resource that is often not available to high-risk victims. Survey results are linked below for the past few years.

- Boston Hospital DV Shelter Survey 2012
- Boston Hospital DV Shelter Survey 2013
- Boston Hospital DV Shelter Survey 2014
- Boston Hospital DV Shelter Survey 2016

b. Examples of Current Partnerships and Projects

Boston healthcare systems, including COBTH DVC member hospitals, maintain a variety of formal and informal relationships with the following types of organizations:

- Domestic Violence Organizations
- Rape Crisis Centers
- Faith Communities
- Regional Service Networks
- State and local public health departments
- State and private schools
- Law Enforcement
- Criminal Justice and Probation Departments
- Children's Advocacy Centers
- Legal Services
- Transportation Services
- Elder Service Organizations
- Neighborhood and Civic Associations
- Community Violence Intervention and Prevention Organizations
- Partnership with Surgeons to provide corrective medical, surgical and dental procedures for injuries related to intimate partner violence

To learn more about specific partnerships, and how they work, contact the COBTH DVC. Members are glad to share detailed information about how the partnerships were formed and how they function. Contact us to request more information.

c. The Strengthening Healthcare Collaborations Project

At the statewide coalition, Jane Doe Inc., the Massachusetts Department of Public Health supports a project which provides community-based organizations with technical assistance and leadership in strengthening collaborations within the healthcare sector. Jane Doe Inc. is a member of the COBTH DVC, and a number of DVC programs are advisors to this collaborative project. Here is the project description of The Strengthening Healthcare Collaborations Project, and contact us for more information.

5 - Education and Training Strategies

a. Overview

The COBTH DVC member programs have extensive experience providing education and training to healthcare providers and other healthcare staff in virtually every department and discipline. They have developed numerous training exercises, PowerPoint presentations, handouts, palm cards and other tools to effectively train providers. Each of DVC programs maintains its own "case vignettes" recognizing the personal, "in-house" stories that are often the most impactful. While general statistics and standard "DV 101" trainings can be informative, healthcare providers want to know how violence impacts their specific patient population and community. They also want to know how to best connect patients with the appropriate in-house resources.
DVC programs recommend the following when developing trainings or educational forums:

- Integrate, integrate, integrate! Get to know the continuing education department and training directors throughout your healthcare organization. Find ways to integrate content about domestic violence and sexual assault into the existing curricula and training structure of the institution.

- DVC members have benefitted from attending national conferences and reviewing a wide variety of training materials on domestic violence and sexual assault. Review existing resources and identify ways to incorporate those materials in your organization, before expending the energy and resources to create new materials.

- Develop a training/awareness strategy that is realistic and matches the existing capacity within your organization. For example, if you plan to train providers how to assess for abuse, first make sure you have a plan in place on how to respond to the probable increase in identification of cases before you begin training. Make sure that you include the institution's protocols and relevant resources in all of your training materials.

- Be flexible, and work toward incremental-change. It will take time to figure out the best strategy, and implement it. Be intentional and clear about the program goals and mission at each step.

- Pay attention to language used when you are training healthcare providers. You may need to use different words and language to better relate to your audience. You do not need to change your underlying message or compromise your integrity, but may need to put it in a context that resonates with your audience. For example, while many in the DV field may prefer the term "survivor" to "victim", if you are training oncologists, they may automatically think that "survivor" refers "cancer survivor" so you may choose to use the term "victim" in your training for clarity.

- Consider adopting a training model where you develop and co-present with a provider who represents the department or discipline in which you are offering the training.
- Tailor everything you present to personalize the issue to your healthcare organization and/or the discipline to whom you are presenting. Citing the national S/DV prevalence statistics and the referring to the health impact information from medical literature is an important first step toward establishing credibility; however, the audience will want to know the issue directly affects their patients or the employees that they see every day in their own settings.
- Consider how you will measure success in your training efforts. At a minimum, an evaluation and feedback form should be used. Follow-up surveys to providers and training participants are additional measures that can help to evaluate changes in knowledge, attitudes and intervention skills.
- Whenever possible, offer continuing education credits to increase the attendance rate of licensed clinicians. Offering breakfast and/or lunch are also helpful benefits to encourage participation.
- Any time spent with a provider that is less than 15 minutes might be best called "an information session" rather than a "training session". Although the content is likely educational, you may want to emphasize that an adequate training on domestic violence/sexual assault intervention requires a longer duration. A program overview or information session can cover some core/basic content, but additional information and program specifics can occur over multiple sessions if there are time constraints. Effective training includes measurable goals related to change in participants' knowledge, attitudes and/or skills.

b. Disciplines Trained

Collectively, the Boston DVC member programs have provided training sessions to virtually every discipline, type of provider and staff person within healthcare, including:

- ***OB/GYN***
- ***NICU***
- ***Support Staff***
- ***Primary Care***
- ***Physical therapy***
- ***Medical and Psychiatry Residents (in a variety of settings)***
- ***Admitting Staff***
- ***Chaplaincy and Pastoral Care***
- ***Psychology and Psychiatry Residents***
- ***Medicine***
- ***Emergency Department***
- ***Behavioral Health***
- ***Nursing Infectious Disease***
- ***Clinic staff***
- ***Medical Legal Partnership***
- ***Social Work***
- ***Case Management***
- ***Patient Family Relations***
- ***Child Witness to Violence Project staff and interns***
- ***Geriatrics***
- ***Occupational and Environmental Medicine***
- ***Women's Health – Primary Care Patient Navigators (in women's health)***
- ***Child Protection Team***
- ***Interpreter Services staff***
- ***Hospital Burn Unit***
- ***Surgery***
- ***Human Resources and Employee Assistance Programs***
- ***Public Safety Officers***
- ***Research Staff***
- ***Patient Advocacy Team***
- ***Orthopedics***
- ***Environmental Services***
- ***Food Services***
- ***Hospital Leadership – Senior Management, Boards of Directors***

c. Training Topics

The DVC programs have provided training to healthcare providers and community partners on a variety of topics, including but not limited to the following:

- How to screen and assess for Intimate Partner Abuse
- How to document disclosures of Intimate Partner Abuse
- Responding to Domestic Violence in Primary Care Settings
- Intimate Partner Abuse and the Impacts on Health
- Intersections of Domestic and Sexual Violence (D/SV) & Addictions
- D/SV & Pregnancy
- Intersection of D/SV & LGBTIQ Communities
- Intersections of DV & Physical ability
- Intersections of D/SV & Elder Abuse
- Intersections of DV & Animal Abuse
- D/SV & Mental Health Issues
- Father's Supremacy Movement and Parental Alienation Syndrome
- Strangulation
- When the Batterer is Law Enforcement
- Danger and Lethality Assessments (based on Dr. Jacqueline Campbell's work)
- Parenting Styles of Batterers
- Impact of DV on Children
- DV, Custody and Parental Kidnapping
- Sexual Assault 101
- Sexual Assault in the context of DV
- DV in Immigrant Communities
- Immigration Remedies for Survivors
- How to Respond to Domestic Violence (for support staff/non- clinicians)
- Responding to Domestic Violence (for direct service and clinical staff)
- How to Handle DV Hotline Calls
- Restorative Justice and DV
- Human Trafficking
- Basics of Intimate Partner Abuse/DV 101
- Teen Dating Violence
- Elders in Violent Intimate Partner Relationships
- Working with abusers
- Mutual abuse assessment
- Mindfulness based strategies with DV survivors
- Animal Cruelty and DV
- Multidisciplinary Responses to Elder Abuse
- Principles of Trauma Informed Care

d. Sample Presentations

DVC member programs have many presentations and online training materials. Please contact us via the survey link to request specific content.

6 - Awareness Month Activities within Healthcare Settings

In 1989 the U.S. Congress passed Public Law 101-112 designating October of that year as National Domestic Violence Awareness Month (DVAM) and such legislation has passed every year since 1989. April is recognized as Sexual Assault Awareness Month. February is both Teen Dating Violence Awareness Month and Human Trafficking Awareness Month. Many DVC programs use these months as an opportunity to sponsor programs and events to educate and raise awareness of domestic violence and sexual assault by hosting programs and events.

a. Domestic Violence Awareness Month

Most healthcare programs use DVAM as an opportunity to sponsor Medical or Nursing Grand Rounds, or create another training forum for healthcare providers. Examples of recent activities by programs are briefly described.

- HAVEN at MGH used DVAM as an opportunity to conduct a suit drive for Tailored for Success, a local organization that provides professional clothing for women entering or re-entering the workforce. Many survivors of violence who face employment disruption and the loss of their possessions use this resource. In addition, HAVEN invited clients to tell their stories in writing. Then, the program sponsored a hospital forum where senior leadership read the clients' stories.
- Boston Medical Center's Domestic Violence Program used the month as an opportunity to train 100 security officers in an intensive four-hour training course on lethality and police responses in domestic violence cases.
- Every October Boston Medical Center's Domestic Violence Program displays the Silent Witness Exhibit over several days in various locations across the hospital/BU Medical School Campus. In February, "Healthy Relationships for Valentine's Day" cards are distributed to patients, staff and visitors. The exhibit and tabling are used to raise awareness about domestic violence and to educate the community about the services available to survivors.
- The Center for Violence Prevention and Recovery at Beth Israel Deaconess Medical Center uses DVAM as an opportunity to train social workers, and to do outreach to nighttime staff. This year, the program sponsored a fundraising and awareness event called "Dancing for Empowerment" featuring belly dancing and Mediterranean food.
- The Domestic Violence Initiative at Lahey Medical Center created an online domestic violence training for all employees. Rolled out during DVAM, there were different versions for clinical/direct care staff and other hospital employees.
- Passageway at Brigham and Women's Hospital has created a spiritually focused forum called "Honoring Survivors" which occurs annually and reaches healthcare providers and hospital staff. Passageway also created the In Her Shoe Project, the theme of which was "walk in my shoes", decorating shoes to tell stories of victimization and survival.
- Community Advocacy Program's recent efforts were designed to be educational, starting with the sobering reality of domestic violence homicides, and then moving to increasingly positive and action-oriented displays. The staff engaged in three weeks of activities:
    - Week 1: Silent Witnesses Exhibit
    - Week 2: Portraits of Survivors Display
    - Week 3: Clothesline Project

Some programs intentionally scheduled domestic violence awareness activities in other months, rather than in October. For example, HAVEN at MGH has a year-end vigil for domestic violence that occurs in December. The Community Advocacy Program uses Valentine's Day to showcase its health relationship campaign, "Love Should Not Hurt". Brigham and Women's Faulkner Hospital used the summer months to do a toiletry drive for a local domestic violence shelter and create awareness about the needs of

survivors, and the BMC Domestic Violence Program coordinates a holiday gift drive in support of a local shelter program each year.

b. Sexual Assault Awareness Month

- The Boston Area Rape Crisis Center (BARCC) sponsors an annual walk to raise awareness and promote community involvement in fundraising for its services. BARCC also holds an annual gala. The COBTH DVC programs have participated in the walk and purchase tables at the gala to provide financial support. The programs have encouraged healthcare providers and staff to participate to learn more about BARCC's comprehensive sexual assault services.
- BARCC launched a media campaign on Boston subways and buses to educate the community about sexual assault.
- The Center for Violence Prevention and Recovery has worked on the Clothesline Project with BARCC, and has displayed some of the t-shirts.

7 - Advocacy Services within Healthcare Organizations

a. Overview and Benefits of Providing Advocacy Services with Healthcare

Integrating advocacy services in healthcare settings creates an important resource for survivors and can have a critical impact on their lives. The services provided by advocacy programs often meet the requirements for healthcare organizations that are set forth by the Joint Commission and other accrediting agencies. An on-site advocacy response increases comfort and competency of providers when asking patients about violence. It also provides timely access to support services for survivors and in-house consultation, training, and support to healthcare staff. One CEO of a Boston-hospital stated that providing domestic violence services was just as important as providing cardiac surgery at his institution. He noted that healthcare institutions have a responsibility to address needs of victims of domestic violence because it is about providing "quality and comprehensive healthcare."

Survivors who may not be ready or able to access shelters or hotlines can still seek healthcare. As healthcare professionals become skilled in routinely assessing for and identifying domestic violence, survivors will receive better care in a number of ways. First, the act of routinely asking about violence in itself is an intervention and sends an important message to patients that their healthcare provider is concerned about their safety and well-being. "Universal education" has long been used as a rationale in Boston, and has become a best practice standard nationwide. Second, the assessment process and availability of an onsite domestic violence and/or sexual violence program offers support services in a setting that is convenient, comfortable, and accessible. Using the "cover story" of seeing a healthcare provider, a survivor who is being monitored closely by their partner can use a medical appointment in order to access services. When a patient discloses abuse, the healthcare provider can refer immediately to the onsite advocacy program for safety planning and ongoing support. Third, onsite advocacy services are an important option for employees who may have challenges easily and safely connecting with help.

b. Descriptions of Services

A detailed inventory of services provided by each DVC member program is included on COBTH's web site.

c. Defining and Describing "Advocacy": What You Call Your Direct Service Component Matters!

One unique challenge for healthcare-based programs is how the concept of "advocacy" services is understood within a healthcare setting. In order to value the services, healthcare providers need to understand what programs can offer and how advocacy makes a difference in the lives of survivors. Testimonials and feedback from de-identified "patients" can be powerful bring back to the providers, along with detailed descriptions of the way that advocate respond to a survivor referred to the program.

Like their community-based counterparts, the DVC member programs hold the principle that "advocacy" is rooted in empowerment and strength-based approaches. First and foremost, all program services are voluntary. This can be confusing in a healthcare setting where referrals are often made from provider to provider, and require the patient follow a prescribed course of care. Unlike provider-to-provider referrals, referrals to advocacy services involve informing the patient about the program and how to access services, without any requirement that the survivor do so. Advocates support survivors in examining options, gathering information, and understanding their rights with the goal of increasing individual safety and well-being. Advocacy is a process-oriented and dynamic interaction between the advocate and the survivor. The survivor is viewed as the expert who is collaborating with the advocate. Together in conversation, through information sharing and brainstorming, the survivor is supported and safety options

are explored. Participation in advocacy services is voluntary for the survivor. The advocate acts simply as an informant and consultant, sharing perspective and coaching the survivor to examine all options. Ultimately, the advocate is neither the director nor the prescriber of a solution; the survivor is the expert in her/his/their own life, understands the abuser and situation best, and decides what is best for her/him/themselves and their family.

One of the COBTH DVC members, Jane Doe Inc., the Massachusetts Coalition against Sexual Assault and Domestic Violence published "For Shelter and Beyond" in 1990. One page titled "Advocacy" includes a straightforward list that contrasts what "Advocacy is…" and what "Advocacy isn't..." The content on that page is still true today.

Advocacy refrains from any intervention without the survivors consent, even if the intervention is meant to be helpful.

A COBTH member, Lorraine Lafata, clinical director of the Community Advocacy Program wrote a thoughtful paper, "Advocacy: Being and Doing." Lorraine's paper details the underlying philosophy and nuanced processes involved in the clinical practice of providing advocacy services.

Advocacy Includes

- listening to the survivor
- believing the survivor is the expert
- respecting the survivor has agency, autonomy and the right to make her/his/their own choices
- recognizing and building on a survivor's strengths
- providing information and resources
- being honest, concerned, authentic

d. Defining "Abuse": Defining the Scope of Services

All COBTH DVC member programs use institutional definitions for domestic and sexual violence, while recognizing the need to refine and revise those definitions as social terms change, questions arise, and time progresses. The terms "domestic violence," "abuse," and "intimate partner violence/abuse" tend to be used interchangeably, as well as "teen dating violence" in reference to adolescents/young adults.

The institutional definition may be stated in policies, trainings and/or in daily practice. Further in this document, there is a section on how to think about the response to types of abuse that falls outside of a program's operational definitions. These situations are referred to as "Non-Intimate Partner Abuse" or "non-IPA". This does not imply that these forms of abuse are any less important, nor any less deserving of a response. When the dynamics and safety issues in these situations are similar to intimate partner abuse, healthcare based programs may be able to assist and can offer important consultation and guidance on how to access other resources.

Excerpts from DVC member programs' definitions of abuse are as follows:

> "Domestic Violence, often referred to as intimate partner violence or battering, is a pattern of behavior used to establish power and control over another person through fear and intimidation, often including the threat or use of violence. It encompasses a number of controlling behaviors that often include but are not limited to: emotional abuse, physical abuse, sexual abuse, and economic abuse."

> "Domestic violence is a pattern of controlling and abusive behaviors that is harmful physically, emotionally and spiritually. Domestic violence is linked to many common health conditions, including anxiety and depression, physical injuries, chronic pain, gynecological disorders, stomach problems, migraines/headaches, and pregnancy complications. If you are being abused, there is caring support available to you where you work or get your healthcare."

"Domestic violence involves a pattern of controlling and abusive (sometimes violent) behaviors that some people use against their intimate partners. Abuse can be physical, sexual, or emotional, and can include threats, isolation, financial control and stalking. Domestic violence is a very common and serious problem that can affect a person's physical and emotional health. It can happen to anyone, no matter who you are or where you come from."

"Sexual assault and rape are crimes of violence and control, using sex acts as a weapon. Rape and sexual assault are not sexually motivated acts; rather, they stem from aggression, rage, sexism, and the determination to exercise power over someone else. Rape is also a legal term that is defined in Massachusetts by three elements: penetration of any orifice by any object; force or threat of force; against the will of the victim. Sexual assault is often more broadly defined as any sexual activity that is forced or coerced or unwanted"

"Domestic violence and sexual trauma affects people of every race, culture, faith, age, gender identity and sexual orientation. People with disabilities, undocumented immigrants and transgender individuals face additional risks.

e. Hiring Program Staff

When hiring domestic violence advocates and program staff, the leaders of the DVC member programs screen candidates for several qualifications, including their ability to work with diverse communities and their ability to work within healthcare setting. Advocates who are accustomed to working within a community setting might find themselves in a steep learning curve when moving into larger healthcare institutions because of the difference in organizational culture. One hospital domestic violence Program Director noted, "Domestic violence advocates in healthcare need to be flexible and skilled. On a daily basis, they need to swim in different waters – sometimes as the tide is changing!"

Advocates need to have patience, empathy, and the ability to navigate the hierarchical structure of healthcare settings. Advocates must be able to manage ambiguity, differing opinions and unsettling outcomes related to injury, poor health prognoses, and dangerous abusive situations. Also, advocates need to be comfortable in guiding, teaching, modeling and mentoring others, including staff, co-workers and healthcare providers who may not fully understand a survivors' choices, or who want to "prescribe" a victim's course of action.

Hiring staff with professional degrees (such as a Bachelor's or Master's) has been considered by some to be helpful in building credibility as an advocate within a healthcare organization, especially in a community such as Boston where most hospitals (and all COBTH member hospitals) are teaching hospitals and affiliated with medical schools. However, program leaders highly value life experience and focus on skills and experiences of potential staff. Degrees alone do not confer the unique perspectives and skill set that advocates find valuable in working with and on behalf of survivors.

Some important qualities to look for when screening candidates for program advocate positions:

- Shared philosophy of empowerment and an advocacy model that focuses on self- determination;
- Reflects the patient population's cultural and racial identities;
- Knowledgeable about key community programs, laws, and other resources needed by survivors;
- Ability to advocate within a variety of institutions, systems, and programs;
- Ability to navigate a professional, medical, hierarchical setting;
- Ability to navigate the relationship between healthcare and the community partners/consumers;
- Ability to work well in a team-setting, where shared decision-making and responsibility is essential to successful interventions and outcomes.

f. Roles and Job Descriptions

Program job descriptions provide information about the role of domestic violence advocates and staff in healthcare.

The following are included:

- Beth Israel Deaconess Medical Center
  - Director, Project Coordinator, Clinical Supervisor, Senior Clinical Social Worker
- Boston Medical Center
  - Program Coordinator and Advocate positions
- Massachusetts General Hospital
  - Director and Advocate positions
- Brigham and Women's Hospital
  - Passageway – Director, Program Manager and Advocate positions

g. Staff Training and Supervision

Newly hired staff and advocates receive orientation to their healthcare setting and to the program's operations. They typically meet with providers in a variety of clinical areas and departments throughout the setting. They shadow and observe current staff within the program before they begin responding to new requests for services and consultation. Like in any other field, performance measures and goals are reviewed within the first 3 months of hire. Additional training opportunities to expand skills and knowledge are sought in a variety of venues, including hospital and healthcare rounds, training sponsored by Jane Doe Inc. (the Massachusetts statewide coalition), community networking events, as well as local, regional and national conferences.

The DVC programs highly value professional development for all staff members whether or not they hold an academic degree or license. There is consensus among the DVC programs that advocates obtain, at a minimum, the 35-40 hour training that all community-based domestic violence programs in Massachusetts require of their staff and volunteers. Many advocates and program staff come to the healthcare setting already having received this training.

Advocates have varied backgrounds, including clinical training and varied life experience. The healthcare setting domestic violence advocate role does not require a clinical license. As a result, the provision of clinical supervision is more of a programmatic choice, rather than a requirement for licensure. Given the intensity and complexity of domestic and sexual violence work in a healthcare organization, programs and survivors are best served by integrating and prioritizing a structure for regular, supportive supervision of staff.

Clinical supervision provides a supportive function, a regular time for attention to staff professional development, and an opportunity to apply research and theory to practice. Most importantly, perhaps, clinical supervision is a venue for advocates to reflect on their use of self in their work with clients. The nature of domestic violence work is such that all advocates and program staff will inevitably experience feelings of frustration, fear, hopelessness and encounter challenging interpersonal dynamics with colleagues and survivors. If left unattended and unexamined, these experiences can lead to less effective advocacy practice, secondary traumatic stress, and staff burnout. Instituting a supervision structure that provides regular, protected time for each staff member to meet with a clinical supervisor will ensure good standards of advocacy practice and staff retention.

Programmatic supervision is also important. This type of supervision helps staff to develop skills in program development, quality improvement initiatives, training and education efforts, and community

collaboration. It provides staff with a place to reflect on the importance of their role within the healthcare setting. It helps staff consider their impact on a wider systems level, which also helps to prevent burnout. Programmatic supervision can be incorporated into clinical supervision or undertaken separately based on program management and structure.

All DVC program staff, regardless of role, must navigate the professional setting and the medical hierarchy with a sense of diplomacy and positive regard for colleagues. It is important that program leaders convey empathy and positive regard for staff. Advocates who feel like their managers understand and appreciate the demands of their role are more likely to work well and sustain their longevity in healthcare work. Fostering teamwork is essential to effectiveness and preventing burnout. Many of the DVC members acknowledge the inevitable secondary or vicarious trauma that staff will experience, and work to mitigate the impact of that stress. As much as possible, they provide flexible work schedules, learning opportunities, team-building and staff retreats to reflect on the work.

h. Staff Support

The leaders of the DVC member programs take care to attend to the needs of staff, particularly the direct service advocates. In addition to providing clinical and programmatic supervision, they all have created structures for staff meetings and case review. They promote a culture of self-care through teamwork so that an individual advocate does not work in isolation. In instances where there is only one staff person within a particular hospital or community health center, the program builds in team meetings with other advocates across the health centers or healthcare system.

Informal networking among peers is encouraged. One program specified in an advocate's job description the number of hours that the advocate was expected to be off-site to attend community meetings and trainings outside of the hospital. While most healthcare providers are expected to work primarily within the walls of their institution, the DVC program staff often must be off-site with survivors, whether in court or supporting them in other systems/settings. Attending trainings, community meetings and other networking forums enhances advocates' abilities to provide effective services. It gives them a chance to connect their daily work within healthcare to a larger movement, to learn about new resources and laws, and to engage with their peers across many different organizations and systems.

The leaders at the DVC programs create opportunities to support staff across institutions. They have sponsored professional development opportunities and staff retreats. They have organized breakfasts and lunches for advocates in multiple healthcare settings to get together and share their experiences and strategize about effective work in healthcare.

Like their counterparts doing community-based advocacy work, many staff members of DVC programs are also survivors of domestic violence and sexual assault, or know someone in their personal lives who has been affected. Beth Israel Deaconess Medical Center's Center for Violence Prevention and Recovery developed a unique and effective program, the Advocacy Education and Support Project (AESP). AESP addresses the issues of secondary trauma on domestic violence advocates, both for those who are survivors themselves and for those who experience secondary trauma through the work. It provides education on secondary trauma, teaches strategies seeks to mitigate its effects, and offers psycho-educational support groups to advocates in a variety of settings, such as healthcare, criminal justice and shelter programs. Providing this type of education and support addresses the feelings of sadness, helplessness, anger, and re-traumatization that can inevitably occur when intervening with intense medical trauma and illness, while simultaneously addressing the impact of violence.

8 - Program Evaluation

The DVC member programs have developed a variety of outcome measures with an emphasis on survivor-defined outcomes. The program leaders have worked closely with their healthcare organizations to explore ways in which domestic violence and sexual assault interventions can be quantified in meaningful ways. The following highlights methods used within programs.

a. Data Collection Tools

Each program maintains unique data collection methods that capture information relevant to whom they are serving and what services they are providing. The data records demographic information, survivors' needs, services provided and the types of abuse/violence experienced by the survivor. The information is used for operational purposes to ensure continuity of care within the program, support program operations, and allow programs to aggregate data to report back to funders.

As a rule, and consistent with community-based practice, DVC programs do not collect or record any data that is not necessary to ensure best practices or seamless coordination of advocacy services. Data, whether on paper or in electronic databases, is kept in secure locations separate from the survivor medical record. Such data is inaccessible to other medical providers.

Programs have used and adapted case management databases such as *Efforts to Outcomes* and *EmpowerDB* to report on program activities. These databases are separate from the medical record and used by DVC program advocates and staff to track services provided to survivors.

b. Feedback and Satisfaction Surveys

The DVC programs have used numerous surveys to elicit provider feedback on advocacy services and to measure domestic violence and program awareness among providers and other employees. Additionally, programs have used surveys to capture client satisfaction and experiences. For example, Boston Medical Center is using a satisfaction survey which is available in three languages spoken by staff. Advocates offer their clients the survey along with a self-addressed stamped envelope and explain that it will be sent to their supervisor, allowing clients to choose whether or not to complete the form, and to answer honestly and anonymously if they do.

The Domestic Violence Program Client Feedback Form is a client progress measure developed by researchers at the Harvard School of Public Health in partnership with four healthcare-based domestic violence programs in Boston. The partnership ran from 2001-2003 and drafted the form in response to the lack of client progress measures designed for use in healthcare-based domestic violence advocacy programs.

The Client Feedback Form may be used to facilitate advocacy work and to evaluate both individual and program outcomes. While the Client Feedback Form was originally designed for use in healthcare-based domestic violence programs, any program providing on-going services to adult survivors may find it useful.

The Client Feedback Form is available in both English and Spanish for programs to use at no charge. Client Feedback Forms and Guidelines for Use can be accessed here.

c. Outcome Evaluation Strategies

An overview document published by the National Resource Center on Domestic Violence provides useful definitions about outcome evaluation in advocacy programs. The work of Dr. Cris Sullivan has been extremely valuable in this field. The Community Advocacy Project has more information.

In the greater Boston area, many domestic and sexual violence programs (including several DVC programs) have partnered with academic researchers to develop outcome tools that are survivor-centered. Dr. Lisa Goodman at Boston College and her colleagues have developed a tool called MOVERS (Measure of Victim Empowerment Related to Safety) in collaboration with advocates and experts in the field.

9 - Challenges of Providing Advocacy Services Within Healthcare Settings

This section reviews some of the challenging issues the DVC member programs have encountered over many years of addressing domestic violence and/or sexual violence in healthcare organizations. The lessons learned and questions we continue to ask are included in the following topics:

a. The Medical Model
b. Family-Centered Care
c. Healthcare Settings as Public Places with Open Access
d. Non-Intimate Partner Violence/Community Violence/Trafficking
e. Mandatory Reporting
f. Child Protection Teams
g. Elders and Intimate Partner Violence and Sexual Assault
h. Addictions and Intimate Partner Violence
i. Mental Health and Intimate Partner Violence
j. Employees Experiencing Domestic Violence
k. Documentation for D/SV Programs
l. Expert Witnesses and Handling Subpoenas

a. Medical Model

The COBTH hospitals are fortunate to have innovative leaders who understand the importance of addressing domestic violence and sexual assault as healthcare issues. The investment of senior management helps create support for the DVC member programs within those institutions. However, on a daily basis, some healthcare providers still ask why we are talking about domestic and sexual violence in this context. Some view it as a psychological or mental health issue, some a criminal justice issues, and some a relationship or private matter. Many continue to presume the solution to domestic violence to be straightforward and clear (e.g. erroneously thinking that the answer is simply ending the relationship, going to shelter, calling the police or obtaining a restraining order). Within a medical model, pathology is sometimes assigned to those who would presumably "choose" to remain in an abusive relationship. The challenge for the healthcare based programs is to reframe these perspectives. In brief office visits and encounters, healthcare providers may find it challenging to take the time to uncover the complexities and barriers facing survivors in accessing supports or increasing safety options. Partnerships between advocates and healthcare providers can greatly enhance provider understanding and healthcare responses to survivors.

Through partnerships, advocates can support providers in managing the complexity of the dynamics involved in abusive relationships. Many providers understandably feel frustrated with the lack of quick resolution to the situation. A sense of fear and helplessness on behalf of a survivor can compound the healthcare provider's desire to "fix" or "treat" the problem, and he/she may recommend, or sometimes, mandate a course of treatment or action. The patient may not be ready or equipped to follow the prescribed course and can end up being labeled as "non-compliant." The medical model and the provider-patient relationship has an inherent power imbalance that can replicate feelings of being overpowered and controlled for the survivor, similar to the ways they are being treated by the abuser. This prescribed/mandated approach may further alienate survivors from using healthcare services in general or the specialized services of the advocacy programs because they can perceive that others will tell them what to do, blame them for their situations, or make things more dangerous or difficult for them.

b. Family Centered Care

The movement in medicine toward family-centered care has been valuable in mitigating patient anxiety about receiving medical care, and recognizes that the family as an essential partner with the healthcare provider in supporting a patient's recovery and well-being. However, this approach presents obstacles to safe and appropriate domestic violence screening and intervention practices. One example is when patients are invited to bring a family member or friend into an exam room or be present throughout an inpatient hospitalization before consulting with the patient her/himself first. Consistent with practice standards recognized by medical professional organizations, including the Joint Commission, the DVC programs have advocated for healthcare providers to build in time to meet with each patient for at least a few minutes alone during each healthcare encounter. Making this practice routine reduces the suspicion that an abusive partner may have about a provider's request to meet alone with a patient. It also avoids the untenable situation where a victim is asked if she/he would like to have their partner or family member present during an exam. It may be unsafe to say "no" to an abusive partner, and the presence of that partner then makes it unsafe at worst, and ineffective at best, for any further discussion of abuse, etc. to take place. In some clinical areas, the DVC member programs have scripted language for healthcare providers to empower them. This includes having providers state it as a matter of policy or routine practice that they take a few minutes to meet alone with their patient. Situations where partners and family members refuse to comply with this request should raise red flags for providers.

Another important consideration is when the provider is caring for both the identified survivors and the identified perpetrator of the abuse or violence. The provider needs to have clear boundaries of confidentiality and avoiding contra-indicated interventions (such as couples counseling or mediation). An advocacy program can offer guidance to the provider about practice and ethical dilemmas that may arise in this type of situation. One DVC member program developed a tip sheet for providers in this dual role.

c. Healthcare Settings as Public Places with Open Access

Many Boston-area healthcare settings, including community hospitals and health centers are public places with open access, with thousands of visitors each day. Healthcare organizations' public safety and security departments are essential collaborators for internal domestic/sexual violence programs. These departments have a pulse on safety precautions and are helpful in advising healthcare based domestic/sexual violence programs on the best way to provide safe access to services. Even when privacy and confidentiality laws are followed, security measures are in place, and providers follow best practices, survivors seeking services in healthcare settings may be seen by abusive partners or their family members who happen to be receiving care, visiting a patient or actively looking for the survivor– literally because there are glass doors, and open public spaces.

DVC member programs have managed these risks in a variety of ways. Most have their direct service offices in restricted access areas or embedded within a larger department (such as social services) with reception staff trained to handle visitors with discretion and safety at the forefront. Some choose not to publish their locations or their staff titles in hospital directories or on their name badges, to maintain some level of confidentiality that community-based programs often practice.

Healthcare organizations' Public Safety and Security Departments can be helpful collaborators for internal domestic and sexual violence programs. When an actual or potential threat to immediate safety is identified, clear and proactive protocols should be well established with Public Safety/Security to address the threat. Additional concerns arise when both the survivor and perpetrator work for the same hospital, or when a patient's abuser works for the hospital. Additional on-site partners may need to include Information Technology, Human Resources, and others depending on the specifics of the situation.

d. Non-Intimate Partner Abuse/Community Violence/Trafficking

While the connections among many forms of interpersonal violence are well understood by the DVC member programs, they have found it is important to clearly articulate their own scope of services, and how and where they address other forms of violence and abuse.

Policies and protocols on responding to cases of non-intimate partner abuse vary among the healthcare DVC member programs. Non-Intimate Partner Abuse (non-IPA) includes family violence, abuse by roommates, landlords, healthcare providers, and both random and intentional community violence by non-related persons. Some programs have expanded their scope beyond domestic and sexual violence to include responses to address community violence and human trafficking. Specialized, nuanced responses consider the context of the current safety concern, and other resources available to address the needs of trafficking and community violence survivors. In settings without the staff capacity to provide a direct service response to non-IPA situations, healthcare DV advocates provide consultation to the providers working directly with these survivors in order to share relevant expertise related to safety planning, risk assessment, legal options and community-based resources.

Collaboration among and between specialized programs is in the best interest of all survivors for many reasons. Some survivors experience multiple forms of abuse/violence and will benefit from providers' sharing of expertise. Some situations that initially present as non-IPA may be found occurring within a larger context of current or past intimate partner abuse, and therefore may better fit the parameters for domestic violence services. For example, cases of abuse of the abuse of an older woman by her adult child can also occur in the context of ongoing abuse by her husband. A teen describing abuse by her "boyfriend" may be talking about a pimp who is exploiting her.

Some of the DVC member programs are working alongside programs and teams that respond to non-IPA. For example, many hospitals in the Boston area have child protection teams, services for victims of trafficking, and victims of gun/gang/community violence. One DVC Member program has a flow chart that is useful in outlining the hospital's responses to violence and its intersection with domestic violence.

Cases of non-IPA referred to healthcare based DV programs can present a challenge in part due to the lack of resources in both the DV program and in the community programs that deal with non-IPA issues.

Given the complexity of cases, the lack of available resources, and the pertinent expertise possessed by healthcare DV advocates, it is likely that many healthcare based programs will continue to see survivors of multiple forms of violence and exploitation. Articulating the scope and limits to program capacity to respond to these cases is helpful. Education and training for staff in community violence and trafficking is essential to ensure best practice responses for all survivors who present in healthcare settings.

e. Mandatory Reporting

It is imperative that DV program staff be very clear on the laws pertaining to mandated reporting in their state. In Massachusetts, there is no mandated reporting to the police or a state agency in the case of domestic violence or intimate partner violence against an adult aged 18-59. There is however, an exception to this law and healthcare providers are mandated reporters to law enforcement in the cases of gunshot wounds, stabbings with knives, and significant intentional burns on a person's body. In addition, it is possible for domestic violence to occur in a context requiring a report to protective services in other cases of abuse (child abuse, elder abuse, abuse of a disabled person) or the required anonymous incident reporting of sexual assaults for the purposes of tracking the prevalence and nature of these crimes.

Some healthcare settings have specific consultation services to address mandated reporting of child abuse, elder abuse, or abuse of the disabled that can arise in the provision of care. Given that many domestic violence victims/survivors will disclose information that can warrant mandated reporting, the healthcare setting DV programs should work closely with specialists in consultation services to assist in the potential necessity of filing and in addressing the safety concerns that can surround reporting. The specialists are typically social workers, physicians, psychologists, and/or attorneys who have varying levels of expertise in domestic violence and may not be familiar with the resources that are available to support victims.

Informed consent with survivors is a key element of domestic violence advocacy. To this end, the DVC programs view their role as informing and educating each individual using the program about the mandatory reporting requirements for all healthcare professionals, such as physicians, nurses, social workers, and others. Complementary to this, the DVC programs encourage and train all mandated reporters to disclose any limits to confidentiality when interviewing all patients.

Healthcare providers should be encouraged to consult with DV program staff around mandated reporting. Laws can be confusing, and many situations are very complex and benefit from multi-disciplinary consideration when determining whether and how a protective services report should be made.

Those who practice through an empowerment and trauma-informed lens maximize informed consent by telling patients about mandated reporting requirements and other limits to confidentiality prior to conducting an interview or providing support services. This gives the person an opportunity to make decisions about how much information to share, knowing the possibility of mandatory reporting exists, which could put the person or family at increased risk for retaliation or further loss of control of their circumstances. One example of how an advocate explains her mandated reporting obligations to program participants is:

> *"Because I am a mandated reporter, if you tell me about any risks or harm to a child, elder, or person with a disability, I may need to report that to the appropriate Social Service agency. My preference will be to talk with you in advance of reporting any concerns so that you can have an opportunity to think through what that will mean and how you may need to plan."*

The above description is followed by concrete examples and a discussion about the potential safety concerns for the individual if a mandatory report were necessary.

Safety planning is crucial once the decision to file a report has been made. Often those coping with domestic violence are afraid of what the abusive partners will do once information is revealed that they have disclosed abuse or sought help. Involve the survivor at every possible step to determine how best the protective service agency can contact her/him/them to learn more about the situation. Be sure to include these specifics about safe contact in the report, and assist the survivor with developing a safety plan for each step of what the investigation might involve.

f. Child Protection Teams

Many who work in health settings serve both adult and pediatric populations. For some in larger healthcare institutions, internal Child Protection Teams consult with providers when issues of suspected or reported child neglect and maltreatment arise.

Given the overlap between domestic violence and child maltreatment, it is important to always be thinking about children and their safety, even when they are not presenting in front of us for care. For many DVC programs, such as HAVEN at Massachusetts General Hospital, a Child Protection Team (CPT) is available help the healthcare based advocacy program staff needs to file a mandated report with

the state child protection services, Department of Children and Families (DCF). In Massachusetts, DCF employs internal Domestic Violence Specialists who are well-versed and helpful as consultants on cases of child protection in the context of domestic violence situations.

COBTH DVC member programs work with their own CPTs and the DV Specialists at DCF to improve system responses for survivors. Through regular meetings and cross trainings, DVC programs can help providers to see the overlapping issues of child abuse and domestic violence. Strong collaboration between DV programs, CPTs within healthcare settings, and child protection services benefits both survivors and their children.

g. Elders and Intimate Partner Abuse and Sexual Assault

Intimate partner abuse occurs throughout the life cycle and affects elders in all types of intimate relationships. Domestic violence and sexual assault programs in healthcare settings are uniquely situated to identify and respond to this group of survivors who may be less likely, due to a variety of barriers, to seek services in community settings.

One of the most important developments in our understanding of elder abuse, which has significant implications for healthcare practice, is the recognition that caregiver stress does not cause someone to be abusive. Responses to abuse that focus only on the needs of the caregiver may at best be ineffective and at worst collude with the abuser. The domestic violence field has taught us that while people who are abusive may experience stress (due to finances, unemployment, life circumstances, and/or related to the care of a family member) these experiences cannot and do not cause an otherwise non-violent, non-abusive person to behave abusively. It is also clear that many older victims are the caregivers for their abusive partners, and that the dependence of an older person on a partner for help with activities of daily living (ADLs) does not necessarily mean s/he can't find other ways of abusing and/or controlling a partner. Advocates working in healthcare settings need to be prepared to encounter those who have different understandings about what causes elder abuse, what are the relevant considerations, and what are appropriate responses and resources to offer.

Another significant development in the field has been increased recognition that the tactics used by those who abuse a partner, survivors' experiences of fear, ambivalence, etc. are often very similar to those tactics associated with abuse of elders by other family members and caregivers, particularly when rooted in power imbalances and abuses of power and control. These dynamics may be compounded by factors associated with ageism, complex family dynamics, and other health and social challenges that come with aging. It is important to recognize that partner abuse against elders may not appear or be identified in the same ways as IPV in younger relationships, in part due to how an older victim might talk (or not) about the abuse, and in part due to the provider's misinterpretation of indicators and other dynamics of the situation. Domestic violence advocates can play a critical role in ensuring that responses to older survivors are truly survivor-centered, trauma- informed, and consider all relevant dynamics, risk factors, options, and resources that may be involved.

It is important to note the continuous learning, broadening of understanding about elder IPV/SA, and expanding resource networks have significant implications for the work of domestic violence programs in healthcare. The COBTH DVC member programs and other members of this multi-disciplinary collaborative have come to recognize that when developing healthcare based advocacy programs, a collaborative, team approach is essential.

Recommended resource for more information: National Clearinghouse on Abuse in Later Life

h. Addictions and Intimate Partner Violence

Substance abuse and partner abuse intersect in complex ways. Many abusive people use substances, often with a purposeful intent to facilitate or excuse subsequent violence. Some abusive people target individuals with substance abuse challenges, just as they often target other historically oppressed and vulnerable individuals. It is also quite common for survivors to use drugs and alcohol – not to mention, food, shopping, self-injury and a variety of other self-harming strategies – to cope in the face of the overwhelming stress of coercion, violence, and entrapment.

The challenge for healthcare-based advocacy programs is that the addictions field and the domestic/sexual violence field have historically come from radically different frameworks. For grounded reasons, addictions counselors may not fully believe what their clients tell them without third party confirmation. For similarly valid reasons, trauma advocates may believe everything that their clients tell them, often precisely because of a lack of third party confirmation. To further complicate matters, traditional addictions counseling models were developed by and for straight, white men with a certain amount of education and privilege. These models rely on an often confrontational approach to recovery that tends not to work well with historically oppressed people – particularly women who have been subject to interpersonal violence. A growing body of evidence indicates that survivors of domestic and sexual violence (and female survivors in particular) experience the best outcomes as a result of integrated trauma treatment that simultaneously addresses both the challenge of addiction and the trauma (of which drug and alcohol abuse is often a symptom).

DVC programs in healthcare settings should be well informed about these intersections and prepared to guide practice in a way that is both trauma-informed and gender-appropriate.

i. Mental Health and Intimate Partner Violence: Promoting Trauma-Informed Care

The interconnectedness of partner violence and mental health has long been recognized, yet our understanding of the complex ways these issues intersect in the lives of survivors continues to evolve. In its early years, the battered women's movement had to counter the misconception that mental illness invited, or even justified abuse by an intimate partner. Activists challenged the notion that the primary reason that batterers perpetrated abuse was because they themselves were mentally ill. We have come a long way from these limited explanations for partner violence. Now we recognize that mental health factors are but one part of a much broader set of personal, political, and economic factors at the family, community, and societal/cultural levels which can influence the choice to abuse a partner. Thanks to the work of Judith Herman and others who recognize the traumatic impact of abuse and the role untreated trauma can play in the long-term safety and healing of survivors, we now more fully understand mental illness as a possible consequence of many forms of traumatic victimization, rather than as a cause. We also have seen more clearly that abusers frequently target those they view (or those who have been labeled) as having mental health challenges, but the cause of their violence is rarely due to their own mental pathology.

Similar to the difference in treatment frameworks of the domestic violence and substance abuse fields, domestic violence and mental health experts also come from radically divergent perspectives. Mental health providers have traditionally been trained to diagnose a pathology, provide treatment (including medication), and make referrals based on that diagnosis. Domestic violence advocates have viewed what may appear as "symptoms of pathology" as expected, and respond to real and overwhelming situations of extreme and/or on-going abuse and control by a partner. At times, the response may in fact be keeping the survivor safe. For example, hyper-vigilance is a natural reaction to repeated, unpredictable attacks and may help a victim by alerting her to situations that pose a threat. Advocates may be concerned that

medicating survivors could dull the very survival instincts that have kept the survivor safe thus far, or that diagnostic labels could suggest that the survivor is the problem rather than the abuse itself.

Many mental health providers are trained to address problems in ways that limit the solutions available in their traditional mental health "tool kit." The solutions often consist of psycho-pharmacology (if available), individual talk therapy, and/or group talk therapy. These modalities limit mental health clinicians to the "what's wrong with you?" framework, locating the problem within the person, rather than "what's happened to you?" framework, which more appropriately recognizes trauma experiences as unwanted and caused by external factors. Although the seminal work of Judith Herman continues to inform trauma services, mental health providers outside of the trauma field often miss the contextual aspect of their client's experience, or only see the context as informing why their clients are depressed or suffering from PTSD, not as an insight on how to approach the trauma.

Advocacy programs within healthcare settings can bring together clinicians with different perspectives to reframe how to best offer support to survivors, increase knowledge and elevate trauma-informed approaches. The National Center on Domestic Violence, Trauma and Mental Health provides valuable resources for programs and advocates. Additionally, the work of Trauma Informed Care on the federal level is blanketing the field of trauma with overarching principles. (more information)

j. Employees Who Experience Domestic Violence

All of the COBTH DVC member programs provide a response to employees in the healthcare setting who experience domestic violence. The inclusion of employees emphasizes the programs' understanding that domestic and sexual violence can happen to anyone. It also recognizes that safety, health, and stable employment are interrelated. It sends a message that anyone coping with domestic or sexual violence is entitled to the same level of care and may benefit from services by a specialized program with trained advocates.

It is important to consider the safety and privacy of the employee and the safety of the workplace when looking at the impact of domestic violence (if any) on work performance. In order to address the many nuances to this work, the COBTH DVC member programs forge connections with Employee Assistance Programs, Human Resources, Occupational Health, and Public Safety and Security departments.

As one example, Partners Healthcare's in-house Employee Assistance Program (EAP) is an excellent resource for model protocols and policies on responding to employee cases of domestic violence. Partners Healthcare's EAP employs a Domestic Violence Specialist, and is a leader in the field of employee assistance and domestic violence responses.

k. Documentation

Both the Violence Against Women Act and Massachusetts state law provide confidentiality protections for the records of and communications with survivors who are the clients of Domestic Violence and Sexual Assault Programs. Programs that stand alone in the community have clear procedures regarding how they keep records of the services and communications they have with clients and others in the course of their work. Programs located within a hospital, health center, or other larger health/ social service agency can face many challenges when balancing their privacy and safety legal obligations with the organization's desire for open communication, data collection, IT security/compatibility, and more.

All Boston healthcare programs that provide direct services have developed databases separate from their larger hospitals'/health centers' electronic medical record (EMR) systems. This allows program staff to appropriately keep detailed notes of client and operational information in a way that cannot be accessed

by other employees/providers. This also cannot automatically be subject to subpoena when a patient's medical record is subpoenaed.

A common challenge which all programs face and respond to in a variety of ways is the desire of other providers within the hospital/health center to know whether referrals to the DV/SA program were received, and whether/how/to what extent the program is connected and will be working with the patient. In many ways, programs strive to reach a certain "status" within the institution, when members of the care team (MDs, RNs, NPs, SWs, and others) view the DV/SA Advocates as peers with important perspectives and expertise. Referrals, consultations, and real-time involvement of an Advocate in challenging situations can result in safer, more appropriate discharge planning, follow-up care, connection to community resources, improved patient satisfaction, and many other positive health outcomes. However, Advocates are required by law to keep the details of their work with patients/clients confidential, unless the client has given express consent to share information. Even this can be limited by the client to only certain information to only certain people. This results in occasional tension when other healthcare providers ask for information about the patient, or when providers request access to the DV/SA Program's records, to which they are not legally entitled.

The key to managing tension and maximizing teamwork across disciplines includes relationship building, cross-training, and on-going communication. When providers understand the laws governing the confidentiality of a DV/SA Program, or when they recognize the risk clients face if others were to have access to their records, they are more understanding of the limits on Advocates sharing information. When Advocates understand providers are asking out of genuine concern, or to help in information to developing a safe discharge plan, they can work with the team and the survivor to ensure appropriate information is shared in the most efficient way possible.

l. Privacy/Internal Communication

Another challenge shared by DVC programs is when medical providers request that DV/SA Advocates document notes in the medical record. Usually, the requested documentation relates to whether the Advocate has met with a patient (typically after a referral has been made) but sometimes the request is for a greater level of detail so the provider knows what was discussed, what safety planning measures are in place, etc. This raises the level of legal risk to Programs. If a survivor is involved in any legal case (civil, criminal, probate, etc.) where medical records are subpoenaed, and there is no direct indication in the record that a patient has worked with the DV/SA Program, then the party seeking information will not automatically have access to the Program's records. However, if an Advocate makes even the briefest notation in the EMR, this can open a door for the court to also request the survivor records documented by the Advocate within the Program database. This can result in a breach of the confidentiality protections for the client.

COBTH DVC member programs have resolved these tensions in a variety of ways. We continue talking with and learning from each other, as there is no one size fits all way of balancing these multiple responsibilities. Two of the DVC programs have a "no notation" policy in regards to the patient's EMR. Two other note only that they received a referral from a provider and the Advocate met with the patient. One program includes a few notes about their impressions of the situation, without including any details of information exchanged or services provided. Another program developed standardized notations that Advocates can select indicating progressive levels of response (without any details regarding what they did or talked about with the patient). Consensus has not yet been attained regarding what is best practice in balancing all these complicated and somewhat conflicting needs. It is important to note that all hospital-based DV/SA Programs should maintain a close working relationship with their internal General Counsel's office, and engage in ongoing dialogue about documentation practices that are both aligned with survivors' rights to privacy and the legal responsibilities of the program.

m. Role in Legal Proceedings -- Expert Witness Requests and Handling Subpoenas

With some exceptions, COBTH DVC member programs largely have kept themselves out of the role of expert witnesses in cases of domestic and sexual violence, for two main reasons. The first, quite practical, is a matter of staff capacity. Programs do not want the role of acting as an expert witness to get in the way of providing acute support services for survivors. The second reason is more complex and speaks to differing conceptions of the role of expert witnessing. Some programs view expert witnessing as an objective role, wherein the expert is a fact finder or investigator. Other programs view the ability to provide expert testimony as another advocacy tool, much like a clinical skill set or legal skill set.

The use of expert witnessing has evolved as the domestic violence movement broadens the conception of power as being strictly a function of gender, requiring both healthcare and community-based programs to develop skill sets around determining who the offender is and who is the survivor. For example, as the field expands in response to the needs of LGBTQ survivors, it is increasingly clear we can no longer assume who is the perpetrator and who is the survivor simply based on the genders of the individuals involved. A more objective set of assessment skills must be employed in the process of accepting clients. Possession of these assessment skills, coupled with a unique expertise in the broader dynamics of domestic violence, has deemed it necessary for some of the COBTH DVC member programs to act as expert witnesses on behalf of clients. One example is providing evaluations to lawyers going forward with immigration cases on regarding the impact of violence. The role of the Advocate in that example is different than serving as an impartial expert witness, but can entangle the Advocate in legal proceedings that are more appropriate for program administrators.

The general protocol for handling subpoenas is to inform the survivor and seek guidance from the healthcare organization's legal counsel. All the COBTH DVC member programs have designated contacts within the legal counsel office of their organization who will assist in addressing legal issues that arise. Many states have community-based resources, particularly within domestic and sexual violence agencies, that may be able to assist survivors in protecting their records against subpoenas. For more information, contact us.

In acute sexual assault cases, the COBTH DVC member programs have largely deferred to the experts at the Massachusetts Sexual Assault Nurse Examiner (SANE) Program. The staff at SANE perform forensic evaluations and are trained to provide expert testimony for criminal court proceedings. However, some healthcare-based programs are providing services for non-acute sexual assault survivors as information and understanding of the health impact grows, particularly in regards to the life-long impact of childhood sexual abuse and enduring impact of chronic partner sexual assault. These services, offered to non-acute assault survivors, are especially beneficial for those who do not have access to the expertise of the SANE Program due to the time that has passed since the assault(s). While providing expert testimony is largely beyond the scope of the healthcare based programs, some programs may choose to provide such services where doing so would be in the best interests of the client.

Recommended resources for more information are: Victim Rights Law Center, National Center on Domestic and Sexual Violence.

10 - Feedback Survey

Like the previous version, we expect to continue to refine this document as we learn more in our daily work, and receive your feedback. We have included a link to a brief survey throughout this document. Readers may use this survey to share input and request further information from the COBTH DVC.

11 - Appendices

Appendix A - Current and Past Domestic Violence Council Member Websites

Beth Israel Deaconess Medical Center – Center for Violence Prevention and Recovery

Boston-Area Rape Crisis Center – Medical Advocacy Program

Brigham and Women's Hospital – Passageway

Cambridge Public Health Department/Cambridge Health Alliance

Child Witness to Violence Project – BMC

Children's Advocacy Center of Suffolk County

Boston Children's Hospital – AWAKE

Community Advocacy Program of CCHERS

Family Justice Center of Boston

Brigham and Women's Faulkner Hospital – Passageway

Journey to Safety – Jewish Family and Children's Services

Lahey Hospital & Medical Center – Domestic Violence Initiative

Massachusetts Department of Public Health

Massachusetts General Hospital – HAVEN

Newton Wellesley Hospital – Domestic Violence and Sexual Assault Program

Northeastern University Law School – Domestic Violence Institute

Partners Health Care Employee Assistance Program

REACH Beyond Domestic Violence

Suffolk County District Attorney's Office – Victim Assistance

Victim Rights Law Center

Appendix B - Massachusetts Resources

Jane Doe, Massachusetts Statewide Coalition

Massachusetts Governor's Council on Domestic Violence

Massachusetts Office of Victim Assistance

Sexual Assault Nurse Examiners Program

Employers Against Domestic Violence (MA)

CrossRoads at North Shore Medical Center, MA

The Second Step