



# BEST PRACTICES IN HEALTH CARE AND DOMESTIC VIOLENCE -LESSONS LEARNED IN BOSTON

Conference of Boston Teaching Hospitals – Domestic Violence Council



Conference of Boston Teaching Hospitals (COBTH)  
Domestic Violence Council

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**LESSONS LEARNED IN BOSTON**

**Table of Contents**

1. [Introduction](#)
  - a. [Background](#)
  - b. [Purpose of this web page](#)
  - c. [Acknowledgements](#)
2. [Description of the COBTH and the Domestic Violence Council](#)
  - a. [Core Values](#)
  - b. [List of Current Members](#)
  - c. [DVC Work Plan](#)
3. [DVC Members: Descriptions of Boston-Area Health Care Domestic Violence Programs\\*](#)
  - a. [DVC Member Programs in Health Care](#)
  - b. [How Programs are Positioned within Health Care](#)
  - c. [Overviews of Health Care Organizations and Members Programs](#)
    - i. [Beth Israel Deaconess Medical Center – Center for Violence Prevention and Recovery \(academic medical center\)](#)
    - ii. [Boston-Area Rape Crisis Center – Medical Advocacy Program \(operates in multiple health care settings\)](#)
    - iii. [Boston Medical Center – Domestic Violence Program \(academic medical center and city’s “safety net” hospital\)](#)
    - iv. [Brigham and Women’s Hospital – Passageway \(academic medical center\)](#)
    - v. [Children’s Hospital Boston – AWAKE \(pediatric academic medical center\)](#)
    - vi. [Community Advocacy Program of CCHERS \(operates in 6 community health centers\)](#)
    - vii. [Faulkner Hospital – Passageway \(community hospital; part of larger health care system\)](#)
    - viii. [Lahey Clinic – Domestic Violence Initiative \(physicians group\)](#)
    - ix. [Massachusetts General Hospital – HAVEN \(academic medical center\)](#)

- x. [Newton-Wellesley Hospital – Domestic Violence and Sexual Assault Program \(community hospital; part of larger health care system\)](#)
    - d. [Populations Served](#)
  - 4. [Strategic Planning: Building and Sustaining the Work in Health Care](#)
    - a. [Advice to New Programs](#)
    - b. [“Start-up” Questions](#)
    - c. [Aligning DV/SA Work with the Hospital/Health Centers’ Missions](#)
    - d. [Family Violence Prevention Fund: Business Case and Public Health Resources](#)
    - e. [Internal DV Leadership Teams/Advisory Committees](#)
    - f. [Funding Strategies](#)
  - 5. [Community Linkages](#)
    - a. [Importance of community partnerships](#)
    - b. [Collaboration between health care and community based domestic violence and sexual assault programs](#)
    - c. [Examples of current partnerships and projects](#)
    - d. [Medical – Legal Partnerships: Two Examples](#)
  - 6. [Increasing Knowledge, Awareness and Skills related to DV in Health Care](#)
    - a. [Overview](#)
    - b. [Education and Training Strategies](#)
    - c. [Disciplines Trained](#)
    - d. [Training Topics](#)
    - e. [Sample Slides](#)
    - f. [Online Education and Web pages](#)
    - g. [Awareness Month Activities](#)
      - i. [Domestic Violence](#)
      - ii. [Sexual Assault](#)
  - 7. [Program Evaluation and Research](#)
    - a. [Data Collection Tools](#)
    - b. [Client Feedback Form](#)
    - c. [Delphi Instrument](#)
    - d. [Balanced Scorecard](#)
    - e. [Surveys](#)
    - f. [Process Data Collection: Examples of Programs’ Services Statistics](#)
  - 8. [Advocacy Services within Health Care Organizations](#)
    - a. [Overview and Benefits of Providing Advocacy Services with Health Care](#)
    - b. [Service Models that differ from Boston](#)
    - c. [Descriptions of Services](#)
    - d. [Definitions of Abuse](#)
    - e. [Challenges of Providing Advocacy services Within the Health Care Setting](#)
      - i. [The Medical Model](#)
      - ii. [Family-Centered Care](#)

- iii. [Health Care Settings as Public Places with Open Access](#)
- iv. [Non-Intimate Partner Violence](#)
- v. [Mandatory Reporting](#)
- vi. [Employees Experiencing Domestic Violence](#)
- vii. [Expert Witnesses and Handling Subpoenas](#)
- viii. [Co-Occurring Issues:](#)
  - (a) [Addictions and Intimate Partner Violence](#)
  - (b) [Mental Health and Intimate Partner Violence](#)
- ix. [Elders and Intimate Partner Violence and Sexual Assault](#)
- x. [Documentation](#)

9. [Advocates/Program Staff](#)

- a. [Roles, with Sample Job Descriptions](#)
- b. [Credentials and Training](#)
- c. [Clinical and Programmatic Supervision](#)
- d. [Relationships Across Disciplines Within Health care](#)
- e. [Support for Advocates and Program Staff](#)

10. [Conclusion](#)

- a. [Boston Programs' Wish List for Future Programming](#)
- b. [Summary of Key Accomplishments](#)

11. [Appendices](#)

- a. [DV Program Materials \(Brochures, Posters\)](#)
- b. [Current and Past COBTH DV Council Members](#)
- c. [Massachusetts Resources](#)
- d. [National Resources](#)

## **I. INTRODUCTION**

### **a. Background**

In 1995, the Conference of Boston Teaching Hospitals (COBTH) convened a Domestic Violence Task Force at the urging of the Boston Mayor and 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 emerged 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 health care.

### **b. Purpose**

The idea for this document was conceived because the DVC receives frequent requests for technical assistance, strategic planning and information from DVC members, health care providers and communities, locally, nationally 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, providers and interested parties who want to strengthen domestic violence responses within health care settings. It is a place to share questions as well as “tried and true answers,” or successful approaches to this complex work in health care. The subtitle of the document is “Lessons Learned in Boston”. More accurately, we might add, “Lessons We Are Still Learning in Boston.” Domestic violence programming in health care is a dynamic field. We are learning on an ongoing basis about better ways to improve the health care responses to domestic violence. This document is formatted as a webpage because we view it as a first draft of sorts -- a snapshot of some of the issues we are discussing and a place to hold shared information. We expect to update and refine it as we learn more in our daily work, and as we receive your feedback.

### **c. Acknowledgements**

A “Best Practices” Working Group has provided leadership in developing this project. Working Group members devoted their time and shared their expertise by compiling materials, brainstorming, conceptualizing the information, and writing sections of the manual. Members include Lisa Hartwick, MSW, LICSW, Director of the Center for Violence Prevention and Recovery at Beth Israel Deaconess Medical Center, Melanie LeGeros, MSW, LICSW, Program Coordinator, Passageway at Brigham and Women's/Faulkner Hospitals, Erin Miller, MEd., Program Coordinator at Newton-Wellesley Hospital, Liz Speakman, MSW, LICSW, Director of HAVEN at Massachusetts General Hospital, and Joanne Timmons, MPH, Domestic Violence Program Coordinator 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. They include: Sue Chandler, Executive Director at DOVE, Inc. and former Director of the Community Advocacy Program; Mardi Chadwick, Director of Passageway; Carolyn Foster, Program Manager at the Boston Area Rape Crisis Center; Jackie Savage Borne, Clinical Coordinator at Passageway; and Bonnie Zimmer, former Director of HAVEN at MGH.

A talented group of Master's level student interns assisted Working Group members in their respective institutions, including Ashley Shoares, Meg Rose, Amanda Kendall, Arlene Vallie, and Elmy Trevejo, RN. We greatly appreciate their support and time on the project.

Special appreciation to John Erwin, Executive Director of COBTH who provided funding for this project, and has been an enthusiastic and consistent participant of the DVC since he joined COBTH in 2005. Jessica Long, Coordinator of Government Relations at COBTH offered valuable insight and technical assistance in managing the project and creating the website.

## **2. COBTH DOMESTIC VIOLENCE COUNCIL DESCRIPTION**

### **a. COBTH Domestic Violence Council - Core Values**

The Conference of Boston Teaching Hospitals (COBTH) has provided a conduit for partnership among the Boston-area health care 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 and intentional collaboration among a variety of organizations and communities. The DVC members understand that a clear vision for ending violence requires a broader analysis of oppression in our society. Understanding and respecting the experiences of diverse communities and survivors is integral to effectively addressing domestic violence. This includes historically underserved communities: people of color; immigrants; GLBTQ people; elders; and people with disabilities. Even well-intended interventions can be re-traumatizing and re-victimizing to victims and survivors of violence. The DVC members strive to be inclusive and aware of the power dynamics that create barriers to assistance for victims of violence. The DVC members share a fervent commitment to providing culturally-competent care. They are invested in creating and supporting environments where diverse life experiences and identities are affirmed and celebrated.

There is tremendous knowledge and wisdom within the DVC, within individuals and programs and as a collective group. The DVC has convened monthly meetings since its inception in 1995. These meetings currently occur on the 3<sup>rd</sup> Friday of each month in Boston, and are always well-attended, and full of candid, lively discussions about challenging issues. The membership includes representatives from hospitals, community health centers, and city, state and non-profit organizations. Please click [here](#) to view a 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 health care responses to domestic violence. In 2007, John Erwin, Executive Director of COBTH, presented the work of the DVC at the Family Violence Prevention Fund's Health Care and Domestic Violence conference ([PowerPoint Presentation](#)).

### **b. COBTH Domestic Violence Council Membership**

When the COBTH Domestic Violence Task Force members created the current Domestic Violence Council, they included health care leaders and community partners such as non-profit domestic violence organizations, Jane Doe Inc. (the Massachusetts Coalition Against Sexual Assault and Domestic Violence), and public agencies, such as the Massachusetts Department of Public Health, and District Attorney's Office of Victim Assistance. Task Force members recognized that any successful effort in health care needed to be developed in partnership with a continuum of services and advocacy groups helping survivors. Membership is open to anyone invested in sharing knowledge and experience and working in partnership with health care. A core group of [members](#) in monthly meetings with a clear agenda ([sample](#)) and work plan.

### **c. Domestic Violence Council (DVC) Work Plan**

A current version of the [DVC work plan](#) is included in this section. The co-chairs of the DVC created this work plan with input from the members. The document is updated annually. It is used as means to orient new members and informs the monthly meeting agendas.



### **Conference of Boston Teaching Hospitals Domestic Violence Council (DVC) 2011 – 2012 Goals and Objectives**

#### **GOAL 1: Strengthen relationships and maximize resources among Domestic Violence Council members and COBTH Hospitals.**

Objective 1.1 – Provide mutual support of DVC members to enhance their abilities to develop and/or maintain quality services, education, prevention and research.

Objective 1.2 – Increase connections and close collegial relationships to sustain leadership within DVC members.

#### **GOAL 2: Strengthen relationships and maximize resources between health care-based and community-based domestic violence programs.**

Objective 2.1 – Identify and address gaps in services and areas for collaboration.

- a. Report on active collaborations within COBTH (between individual programs and COBTH member participation in other forums) on a quarterly basis.
- b. Provide opportunities for members to report on projects they are seeking active collaborators for.
- c. Invite Community and Governmental agencies such as, Safelink, DTA, DCF as needed to inform or address the DV Council.

Objective 2.2 – Identify areas for shared programming related to service delivery, education and prevention.

- a. Report on programming, service delivery, education or prevention activities

#### **GOAL 3: To address the complex needs of survivors.**

Objective 3.1 – Influence the mental health response to survivors.

- a. Keep a pulse on access to mental health services of survivors.
- b. Invite various groups/individuals working on mental health issues –Trauma Informed Care, Representative from NESTDD
- c. Compile a list of mental health providers to be accessed through the members only section of the COBTH website

Objective 3.2 - Influence the legal response to survivors

- a. Keep a pulse on the legal needs of survivors and the response of health care programs
- b. Invite legal programs/attorneys or other entities who can inform the D.V. Council of current issues facing provision of legal services
- c. Compile a list of pro bono attorneys which can be accessed through the members only section of the COBTH website
- d. Collaborate with other groups working on improving the legal response to D.V. survivors

Objective 3.3 - Discuss and address the ongoing work of high risk teams and lethality assessments

- a. Provide time within the D.V. Council to update members regarding the work of high risk teams and the work being done regarding lethality assessments
- b. Discuss the options for medical settings to address lethality concerns either through assessment, teams or other vehicles

#### **Goal 4: To integrate sexual assault response and prevention with the work of the Domestic Violence Council**

Objective 4.1. Elicit/listen for ways to partner and collaborate with sexual assault services

- a. Use April COBTH D.V. council meeting to mark sexual assault awareness month
- b. Look for other opportunities to collaborate with organizations doing sexual assault work within the Boston area

Objective 4.2 Dedicate time to address sexual assault within the D.V. Council



- a. Delineate the common and divergent elements of sexual assault and domestic violence response and prevention
- b. Discuss the pros and cons of establishing screening for sexual assault within medical settings

**GOAL 5: Update the D.V. Council manual of best practices as new information is available, changes in recommended practices are developed, with the goal of implementing and successfully integrating health care-based domestic violence advocacy programs within health care settings, such as academic medical centers, community hospitals, and health care centers.**

Objective 5.1 - Identify areas of recommended practices for documentation in a manual (e.g., service delivery, philosophy, mental health, documentation, "how to" program models, program evaluation, etc.)

- a. Once manual website is live (expected February 2011, promote the website to Jane Doe, Family Violence Prevention Fund, and Department of Public Health. Encourage members to also link to the website
- b. Update manual as changes are deemed appropriate, given changing technology, policies or practices
- c. Review twice yearly for needed changes and/or to ensure that the site is working properly

**GOAL 6: Share training and educational resources among DVC members in order to maximize resources and identify areas for collaboration to fill gaps in training.**

Objective 6.1 – Compile an inventory of current trainings offered by DVC members

**GOAL 7: Increase activism statewide and nationally in favor of important policy and legislation related to domestic violence and sexual assault.**

Objective 7.1 – Identify areas of relevant legislation and increase awareness among DVC members.

- a. Increase in legislative issues being brought to D.V. Council of COBTH
- b. Invite Policy and Legislative staffer from Jane Doe to attend yearly to give legislative updates and engage D.V. Council

**GOAL 8: Integrate prevention efforts within the activities of DVC Members**

Objective 8.1 – Identify concrete ways to integrate prevention efforts within the activities of DVC members.

- a. Identify and implement an event as the D.V. Council of COBTH to highlight Health Care Day (October 2011 and/or 2012)
- b. Plan, implement and coordinate a college project to address relationship violence with area colleges, sexual assault, domestic violence and health care programs
- c. Reach out to member contacts within colleges in order to vet ideas for best project to connect D.V. Council of COBTH

**GOAL 9: Keep current in relevant literature and research opportunities**

Objective 9.1 – Create a venue once yearly to review current research

- a. Reach out to researchers who would present relevant topics to the D.V. Council of COBTH. Some of the researchers thought of were Jay Silverman Ph.D., Roz Wright M.D. Reach out to researchers

### 3. DVC MEMBERS: BOSTON-AREA HEALTH CARE DOMESTIC VIOLENCE PROGRAMS

#### a. DVC Member Programs in Health Care

In 2004, the COBTH DVC members put together this [graphic timeline](#) to highlight the accomplishments in domestic violence and health care responses. The timeline was presented at the Family Violence Prevention Fund Conference.

Although the graphic has not been updated, there have been new developments in the greater Boston-area to add to this timeline, such as:

- 2005 Passageway/Brigham and Women's Hospital launches a legal service partnership: The Passageway Health Law Collaborative with Harvard Law School's Legal Service Center.
- 2007 Boston Medical Center launches its Domestic Violence Program.

- 2008 Newton-Wellesley Hospital launches its Domestic Violence/Sexual Assault Program.
- 2008 Massachusetts Department of Public Health declares a [Public Health Advisory](#) on Domestic Violence.
- 2010 – COBTH hosts [Partnering Youth and Health Care to Prevent Teen Dating Violence](#)

Boston-area health care domestic violence programs\* share similar goals and underlying philosophies. Goals include enhancing safety of victims, holding abusers accountable, and improving the health care response to domestic violence. Similar philosophies include respecting autonomy and the rights of victims, using trauma-informed approaches to care, and understanding the inherent conflicts within the medical model and empowerment-based services. The programs also have similar models of advocacy services with strong collaboration within the health care setting and with community partners. As the literature suggests, health care responses to domestic violence can offer safe space and neutral ground for victims to seek assistance. The programs serve victims and survivors of all ages, from adolescents to elders, and strive for universal screening and assessment so that those impacted by domestic violence can be offered support, a compassionate response and options to increase their safety.

Another similarity among the Boston programs is that they all respond to survivors who receive care and/or are working in the health care setting. Many employees in health care are also patients of the hospital or health center where they work. The commitment to serve both employees and patients recognizes that domestic violence is a highly prevalent issue. Although anyone may be referred to the program as a “patient” and/or as an “employee”, the distinction may be necessary to reflect the types of safety planning needed in order to appropriately respond to that individual. Responding to domestic violence in the lives of employees requires nuanced responses to promote their individual safety while addressing the impact and potential threats in the workplace. In order to truly effect change and create a safer and healthier community, health care organizations must respond to both employees and patients who experience domestic violence.

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\*Boston-area health care domestic violence programs will be referred to as “the programs” or “the Boston programs” for the remainder of this document.

## **b. How Programs are Positioned in Health Care Organizations**

The structures of the Boston programs vary, and depend somewhat on the organizational structures of their individual health care organizations. It matters where the programs are positioned within the organization. Specifically, there have been efforts to ensure that the mission of the domestic violence program is strategically aligned with and contributes to the institution’s mission. It has been important 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.

**Three examples** of where a domestic violence program is positioned within a hospital setting:

1. Newton-Wellesley Hospital's dual domestic violence and sexual assault program is positioned within nursing leadership and Community Benefits. The coordinator, who was hired in 2008 to launch the program, will tell you that as the solo staff person, it was clear that she needed support and buy-in to develop this new program. A seasoned nursing director was the best person to provide operational support, access to decision-makers, forums for training and education, and strategic planning. An active Community Board is an important component to the development of NWH's program.
2. The Center for Violence Prevention and Recovery (formerly Safe Transitions) at Beth Israel Deaconess Medical Center is positioned within the hospital's Social Work Department. Within this hospital, the social work director plays a similar role as the nursing director at Newton Wellesley Hospital. In addition, the Center responds to both domestic violence and sexual assault. As a dual program with a relatively small staff, the Center relies on 24-hour partnership with the hospital's social workers. Being part of the Social Work Department promotes strong internal support for all of the staff. There is a consistent standard of care for victim services.
3. Passageway at Brigham and Women's Hospital is positioned in the Center for Community Health and Health Equity (CCHHE). The CCHHE (formerly the Center for Perinatal and Family Health and the Office for Women, Family and Community Programs) is charged with addressing community health and disparities in health care. Passageway leadership can tell you how this is a strategic advantage within its hospital system. It provides the program with technical assistance, operational support, strategic planning, community partnerships and funding opportunities.

**c. Health Care Organizations and Program Overviews**

The following link provides a list of [COBTH member programs](#) and an inventory of services provided at each program as well as a list of [common definitions](#).

Examples of program materials, including brochures, resources cards, and posters for the Boston programs are included in [Appendix A](#) at the end of this document.

As noted in the previous section, is important to recognize that each Boston-area health care domestic violence and/or sexual assault program is shaped by the organizational culture of the institution in which it operates. For people who are in the process of developing new programs, the brief descriptions that follow are intended to provide a context for the Boston programs:

- I. Beth Israel Deaconess Medical Center and the Center for Violence Prevention and Recovery;
- II. Boston Area Rape Crisis Center (BARCC) and the Medical Advocacy Program (in multiple hospitals);
- III. Boston Medical Center and the Domestic Violence Program;
- IV. Brigham and Women's Hospital and Passageway;

- V. Children's Hospital Boston and the AWAKE Program;
- VI. The Community Advocacy Program of CCHERS (at community health centers);
- VII. Faulkner Hospital and Passageway at Faulkner;
- VIII. Lahey Clinic and the Domestic Violence Initiative;
- IX. Massachusetts General Hospital and HAVEN at MGH;
- X. Newton-Wellesley Hospital and the Domestic Violence and Sexual Assault Program.

## **I. Beth Israel Deaconess Medical Center, Boston, MA**



**Beth Israel Deaconess  
Medical Center**

*A teaching hospital of Harvard Medical School, Beth Israel Deaconess Medical Center (BIDMC) is renowned for excellence in patient care, biomedical research, teaching and community service. Located in*

*the heart of Boston's Longwood Medical and Academic Area, it hosts nearly three quarters of a million patient visits annually in and around Boston.*

*BIDMC has 621 licensed beds, including 419 medical/surgical beds, 77 critical care beds and 60 OB/GYN beds. It has approximately 5,000 births a year, as well as a full range of emergency services, including a Level 1 Trauma Center and roof-top heliport. The Beth Israel Deaconess Learning Center offers patients and families up-to-date health information and access to current research on a wide range of medical conditions. The following statistics reflect the medical center's volume of patient care:*

- *Inpatient Discharges*  
2009 - 41,125
- *Outpatient Visits*  
2009 – 532,237
- *Emergency Department Visits*  
2009 – 53,270



**Center for  
Violence Prevention  
and Recovery**

### **The Center for Violence Prevention and Recovery**

The Center for Violence Prevention and Recovery (CVPR) at BIDMC began in 1994 as a domestic violence program, Safe Transitions. In 1997, Safe Transitions merged with

the hospital's 30-year old Rape Crisis Program to become the CVPR, a program of the hospital's Social Work Department. The CVPR is designed to provide direct services to patients and employees, as well as to educate the medical center staff and community on issues of domestic violence, sexual assault, and other forms of interpersonal violence. The Center has a long history of strong partnerships with community-based organizations, including community health centers in Boston.

CVPR employs a full-time director, one full-time advocate, one 30 hour/week clinician, one 34 hour/week program supervisory, and supervises MSW/social work interns during the academic year. The Director estimates that over 50% of the program's time is spent providing direct services (with the exception of the Safe Bed program), 15% of the time is spent engaging in community partnerships; 10% in the Safe Bed program (which temporarily shelters victims); and

another 10% providing training, education and awareness. The remaining 15% breaks down to 5% each spent on program development, program evaluation and prevention work.

## II. [Boston Area Rape Crisis Center, Cambridge, MA](#)



*The Boston Area Rape Crisis Center (BARCC) is the only rape crisis center in the Greater Boston area and the oldest and largest center in Massachusetts. The organization's vision is to end sexual violence through healing and social change.*

*BARCC was founded in 1973 by a group of women dedicated to building a hotline to answer calls from rape survivors. Today, BARCC is a national leader in providing comprehensive, free services including a 24-hour hotline, 24-hour medical advocacy, individual and group counseling, and legal advocacy. BARCC also provides community awareness and prevention services through partnerships and training with organizations and communities. The organization has 22 full-time staff including licensed clinical staff, legal staff, and educators, 140 active volunteers, and clinical, legal, public health internship programs. Its medical advocacy program operates in multiple hospital emergency departments.*

### Medical Advocacy Program

A full-time program manager for the Medical Advocacy program works with trained volunteer medical advocates and paid nursing staff through a partnership with the statewide Sexual Assault Nurse Examiner's (SANE) program. The program manager estimates that 75% of the program's time is spent providing direct services to clients; 10% is spent in community partnerships; another 10% is spent in program evaluation and quality improvement; and the remaining 5% is spent providing training, education and awareness of sexual assault.

### III. [Boston Medical Center, Boston, MA](#)



*Boston Medical Center is a private, not-for-profit, 639-licensed bed, academic medical center located in Boston's historic South End. The hospital is the primary teaching affiliate for Boston University School of Medicine. Boston Medical Center emphasizes community-based care, with its mission to provide consistently accessible health services to all. The largest safety net hospital in New England, Boston Medical Center provides a*

*full spectrum of pediatric and adult care services, from primary to family medicine to advanced specialty care. With the largest 24-hour Level I trauma center in New England, its Emergency Department had 131,288 visits last year.*

*Additional statistics for 2009 include*

- 30,250 discharges
- 568,632 outpatient clinic visits
- 4,723 FTEs, 1,598 of whom are nurses

#### **BMC Domestic Violence Program**

The BMC Domestic Violence Program was launched in 2007 after a long history of providing services to children who witness violence, including domestic violence, and a partnership with Northeastern University School of Law's Domestic Violence Institute that provides support to victims in the hospital's Emergency Department. An active hospital-wide Advisory Committee began the program after careful planning and consideration about the capacity to address the issue of intimate partner violence. The Director of the Child to Witness Project at Boston Medical Center, along with health care leaders and administrators at BMC have made significant contributions to the development of the program and remain actively involved.

Boston Medical Center's Domestic Violence Program works to improve and coordinate the institution's response to domestic violence through training, education, and awareness, policy and protocol development, consultation and technical assistance, direct advocacy/support and connections to community resources. Direct services provided by the Program's Safety and Support Advocate include crisis intervention and supportive counseling; risk assessment and safety planning; assistance with obtaining restraining orders, victim compensation, and a wide range of additional resources and benefits; accompaniment to court and other appointments; advocacy with a wide range of legal, medical, housing, and other systems as needed; identification of additional advocacy needs and resources.

The full-time program coordinator spends about 40% of her time doing training and policy-related work; 20% of her time developing and supporting partnerships; 20% of her time developing the program; 10% of her time evaluating the program; and 10% of her time engaging in prevention activities. With the support of a VOCA grant awarded in 2009, the program recently added one full-time advocate who spends about 90% of her time providing direct services, and 10% of her time fostering community partnerships. The need for more than one advocate was clear from the start, and the hospital is in the process of securing funding for a second full time direct service position.



#### **IV. Brigham and Women's Hospital, Boston, MA**



#### **BRIGHAM AND WOMEN'S HOSPITAL**

*Recognized internationally for its excellence in patient care, its outstanding reputation in biomedical research, and its commitment to educating and training*

*physicians, research scientists and other health care professionals, Brigham and Women's Hospital (BWH) is a 777-bed teaching affiliate of Harvard Medical School located in the heart of Boston's renowned Longwood Medical Area. Along with its modern inpatient facilities, BWH boasts extensive outpatient services and clinics, neighborhood primary care health centers, state-of-the art diagnostic and treatment technologies and research laboratories.*

*Annual statistics for BWH include:*

- *Inpatient admissions totaled approximately 44,000.*
- *Ambulatory visits grew to more than 950,000.*
- *The Emergency Department treated 54,000 patients.*
- *As New England's largest birthing center, and a regional leader in high-risk obstetrics and newborn care, approximately 9,000 babies are born annually at BWH, and the Newborn Intensive Care Unit cares for more than 1,300 infants annually.*
- *BWH employs more than 12,000 people; 3,000 physicians, fellows and residents; more than 1,000 researchers; and 2,800 nurses.*



#### **Passageway at Brigham and Women's Hospital**

Passageway, the BWH domestic violence program was launched in 1997. It was developed by a hospital-wide Domestic Violence Advisory Committee after a long

history of leadership in responding to domestic violence in women's health. Passageway provides direct advocacy services to patients at the BWH, Southern Jamaica Health Center and the Martha Eliot Health Center. Advocates provide services such as safety planning and risk assessment, individual counseling and support, referrals to community agencies and information on the health effects of domestic violence. They work closely with the providers to provide support, education and consultation about intimate partner violence. It also has an innovative legal services component, the Passageway Health Law Collaborative, a partnership with Harvard Law School's WilmerHale Legal Services Center in Jamaica Plain, MA. Passageway has recently hired a part-time Prevention Specialist to begin developing a prevention strategy for the program.

Passageway employs one full time Director, five full-time staff, three part-time 20 hours/week employees, and as well as MSW/social work interns during the academic year. The Director estimates that 60% of the program time is spent providing direct services to clients; 15% of the time is spent providing training, education and awareness activities of domestic violence; 15% of the time is spent working on prevention activities and the remaining 10% is spent on program development, evaluation and quality improvement.

## **V. Children's Hospital Boston and the AWAKE Program, Boston, MA**



### **Children's Hospital Boston**

*Children's Hospital Boston is a 392-bed comprehensive center for pediatric health care. As one of the largest pediatric medical centers in the United States, Children's offers a complete range of health care services for children from birth through 21 years of age. Children's records approximately 25,000 inpatient admissions each year, and our 225 specialized clinical programs schedule more than 524,700 visits annually. Additionally, the hospital performs 25,000 surgical procedures and 200,000 radiological examinations every year.*

*The hospital's clinical staff includes approximately 1,077 active medical and dental staff, as well as 980 residents and fellows, 1,596 nursing and clinical personnel, and 5,200 other full- and part-time employees. Children's Hospital Boston also has a diverse trained team of more than 830 volunteers.*



### **AWAKE (Advocacy for Women and Kids in Emergencies)**

Since 1986, AWAKE has offered comprehensive, ongoing intimate partner violence (IPV) services to patients, parents/caretakers of patients and employees at Children's Hospital Boston. AWAKE provides risk assessment and safety planning, individual counseling in person or by phone, criminal justice advocacy, assistance with emergency housing needs, public advocacy, referrals for legal services and other resources, and weekly support groups for survivors of violence. In addition, AWAKE provides consultation to health care providers and trainings at Children's Hospital and in the community.

The AWAKE Project currently employs one full time Clinical Coordinator and two MSW/social work interns during the academic year. There is back-up coverage available through the Child Protection Program. The Clinical Coordinator estimates that 70% of her time is spent providing direct services to clients. Another 20% is spent providing training, education and awareness, and another 10% is spent engaging in community partnerships, all in the service of direct client care.



## **VI. Community Advocacy Program of CCHERS, Boston, MA**



*The CCHERS Community Advocacy Program (CAP) supports Family Advocates at six of its partner community health centers in Boston: Bowdoin Street Health Center; Codman Square Health Center; The Dimock Center; Dorchester Multi-Service Center; Geiger Gibson Community Health Center; and Neponset Health Center.*

The Family Advocates provide a range of services to victims and survivors of dating and domestic violence and their loved ones, including:

- crisis intervention
- safety assessment and planning
- advocacy
- assistance with housing and shelter
- legal assistance, including court accompaniment
- information and supported referrals
- support groups for adult women and teens.

CAP employs a full-time director, six full-time staff, and one part-time clinical supervisor. An estimated 50-60% of the program's time is spent providing direct services to clients throughout six community health centers. The program spends about 15% of its time in program development, and another 15% in community partnerships. Between 5-10% of the time is spent in training, education and awareness activities. The remaining 5-10% of time is spent engaging in prevention and program evaluation.

## **VII. Faulkner Hospital, Jamaica Plain, MA**



**FAULKNER HOSPITAL**

*Faulkner Hospital is a 150 bed non-profit, community teaching hospital located in Jamaica Plain, just 3.4 miles from the Longwood medical area. Founded in 1900, Faulkner Hospital has a long history of meeting the health care needs of the residents of southwest Boston and surrounding suburbs. Faulkner offers comprehensive medical, surgical and psychiatric care as well as complete emergency, ambulatory and diagnostic services. Its largest inpatient services are internal medicine, cardiology, psychiatry, pulmonary, orthopedics, gastroenterology and general/GI surgery. In fiscal year 2009, Faulkner Hospital had over 8,200 discharges and provided ambulatory services for more than 210,000 patient visits.*

*In 1998, Faulkner Hospital, highly regarded as one of the region's most respected community teaching hospitals, joined with Brigham and Women's Hospital, one of the country's leading academic medical centers, to form a common parent company, Brigham and Women's/Faulkner Hospitals, a member of Partners HealthCare System.*



### **Passageway at Faulkner**

Passageway at Faulkner was launched in 2004, as an extension of Passageway at Brigham and Women's Hospital (BWH). It was evident that a full-time

coordinator on-site at Faulkner would enhance its ability to address domestic violence among patients, employees and the community. Passageway at Faulkner has demonstrated effective and innovative community collaboration through its work with SAGE-Boston, a group addressing domestic violence and elder, and with neighborhood coalitions and task forces.

At Passageway at Faulkner, there is one full time program coordinator, with back-up coverage through BWH. The Program Coordinator estimates that 40% of her time is spent providing direct services to clients. Another 30% is spent providing training, education and awareness, and another 20% is spent engaging in community partnerships. The remaining 10% of the time is divided between prevention efforts and program evaluation/quality improvement.

### **VIII. Lahey Clinic, Burlington, MA**



*Lahey Clinic is a physician-led, nonprofit group practice. Nearly 450 physicians and more than 4,000 nurses, therapists and other support staff work together to provide compassionate care. The Clinic's multidisciplinary approach allows patients to access to preeminent physicians from virtually every medical specialty, who cooperate to develop personalized treatment plans for each patient.*

*From advanced technology to research and medical education, Lahey Clinic combines the renowned specialty resources of its medical centers with top-quality primary care services at community-based practices throughout northeastern Massachusetts.*

*Lahey Clinic Medical Center in Burlington encompasses an ambulatory care center serving more than 3,000 patients each day and a 317-bed hospital. Lahey Clinic Medical Center, North Shore, in Peabody, serves more than 800 outpatients each day and includes a 10-bed hospital. Both feature 24-hour emergency departments, and an American College of Surgeons verified Level II Trauma Center is based at the Burlington facility.*

### **Lahey Clinic - Domestic Violence Initiative**

Lahey Clinic has a long history of collaborating with local police and community organizations to provide crisis intervention and links to services for victims of domestic violence. Lahey and these partners are committed to alleviating the public health and social problems associated with relationship violence in all forms, including spousal violence and elder abuse.

Formed in 1992, Lahey's Domestic Violence Initiative (DVI) is a group that includes physicians and non-clinical staff from departments such as Gynecology, General Internal Medicine, Social Work and the Emergency Room. Community members include law enforcement representatives and local emergency resource groups.

Lahey Clinic's DVI has goals aimed at both institutional and community knowledge of domestic violence. The group endeavors to increase the public's awareness of domestic violence and provide leadership to the clinic and the community regarding domestic violence.

The DVI is active in training Lahey staff to work with community agencies to recognize and respond to the needs of victims of violence and maximize compliance with mandatory reporting requirements. Lahey Clinic serves as a resource to the surrounding communities by providing immediate help in a crisis and serving as a safe haven for victims in need of protection and services.

According to the coordinator of Lahey's DVI, "Lahey's goals are to heighten awareness of the issue; provide crisis intervention and links to services; strengthen community partnerships, and train the clinical staff to recognize and respond to the needs of victims."

## **IX. Massachusetts General Hospital, Boston, MA**



**MASSACHUSETTS  
GENERAL HOSPITAL**

*Massachusetts General Hospital (MGH) is a 900-bed medical center, located in the heart of Boston, and offers sophisticated diagnostic and therapeutic care in virtually every specialty and subspecialty of medicine*

*and surgery. MGH offers high-quality care and services in four health centers in the Boston area. The hospital also holds concurrent Level 1 verification for adult and pediatric trauma and burn care.*

*MGH's five multidisciplinary care centers in cancer, digestive disorders, heart disease, transplantation and vascular medicine unite specialists across the hospital to offer patients comprehensive, state-of-the-art medical care and the best possible outcomes. In addition, MassGeneral Hospital for Children provides a full range of pediatric health care services, from primary care to cutting-edge treatments of complex and rare disorders.*

*At MGH's main campus and its four health centers in Charlestown, Chelsea, Revere and the North End, Mass General annually:*

- *Admits 47,000 inpatients*
- *Handles nearly 1.5 million outpatient visits*
- *Records 83,000 emergency room visits*
- *Performs 37,000 operations*
- *Delivers 3,700 babies*



**HAVEN**

**HAVEN at MGH**

HAVEN opened its doors in 1997 after a long history of domestic violence education and awareness at Massachusetts General Hospital. It is an innovative program that views itself as part of a broader community response to end intimate partner abuse by improving and enhancing the health care organization's response and care to patients and employees whose lives have been impacted by domestic violence.

Advocates at the main campus, and at MGH's community health centers in Chelsea and Revere, provide voluntary services which may include: risk assessments, safety planning, individual and

group support, referral and linkage with community resources. The program has an excellent education and training program, has ongoing support groups for survivors, and engages in community outreach. Its latest partnership is with the ROSE Fund in Boston to provide free, reconstructive surgeries to victims of abuse.

HAVEN has a full-time director and five full-time staff. The HAVEN Director estimates that about 75% of the program's time is spent providing direct services to clients. The remaining 25% is divided between training/education/awareness (10%), community partnerships, program development and program evaluation (5% each).

#### **X.     Newton-Wellesley Hospital, Newton, MA**



**NEWTON-WELLESLEY  
HOSPITAL**

*A comprehensive medical center located in Newton, Newton-Wellesley Hospital (NWH) provides the services and expertise of a major medical facility with the convenience and personal attention of a community hospital. The Hospital is committed to delivering high-quality, safe and efficient medical care to each and every patient.*

*Newton-Wellesley Hospital is a member of [Partners HealthCare](#), a network founded by Massachusetts General Hospital and Brigham and Women's Hospital. This Partners affiliation allows NWH to provide patients with seamless accessibility to the finest community-based medicine as well as the most advanced specialty care in the world. Through multiple collaborations with Massachusetts General Hospital, MassGeneral Hospital for Children and Brigham and Women's Hospital, NWH offers patients access to various centers of excellence.*

*At its 289 bed facility, Newton-Wellesley Hospital had 17,763 discharges in FY2008. The hospital delivered nearly 3,300 babies, and had 56,636 emergency visits. It performed 10,982 outpatient surgical procedures and provided 59,243 rehabilitation services.*

#### **NWH Domestic Violence and Sexual Assault Program**

Newton-Wellesley Hospital's dual domestic violence and sexual assault program was launched in 2008 after a long-standing commitment at the hospital to building strong community partnerships with domestic violence and sexual assault programs, responding to employees experiencing domestic violence and developing educational and awareness materials.

There is one full-time program coordinator at NWH who spends about 70% of her time providing direct services to clients, 10% of her time providing training, education and awareness to the staff, another 10% of her time working on community partnerships, and the remaining 10% of her time divided between program development and engaging in program evaluation and quality improvement. The program is in the process of developing a clinical intern component in order to build capacity to respond to the high demand for advocacy services.



### **Important Considerations Regarding Program Development:**

The Boston programs vary in program structure and stages of development. Along a wide spectrum, there are new programs with one staff person responsible for all program activities and there are well-established programs with several staff in differentiated roles who serve multiple sites. One important lesson learned is that in order to build effective programs, realistic goals for staff positions must be created from the start. Although it is common for programs to be implemented initially with only one staff position, it is not viable for one person to be “the program.” Both research and practice have shown that a high volume of domestic and sexual violence victims are present within any health care setting as patients and employees. After a program is launched, it is only a matter of time before the need and demand for crisis intervention and direct services will exceed the capacity of one staff person who has a variety of other job responsibilities.

The first goal of all new programs should be to assess the health care organization’s needs and develop a plan to build service capacity. The Boston programs recommend that start-up programs proceed cautiously and limit the scope of direct services until such a plan is in place. The plan may include hiring direct service staff, and/or contracting with community-based agencies to provide direct services. When deciding what your program will offer and what role(s) it will serve within your organization, it is important to think carefully about a realistic and sustainable workload for staff. More than one or two people are needed to adequately staff the different and equally important functions of a comprehensive program, such as developing a systemic response to violence, providing direct services, training health care providers, collaborating with the community, and engaging in violence prevention efforts.

#### **d. Populations Served by Health Care Programs**

The Boston-area programs share a commitment to providing culturally competent, trauma-informed services to victims/survivors of intimate partner violence. Within each program, the victims/survivors who receive assistance tend to be patients, employees and community members across the lifespan (from adolescents to elders). While to some extent populations served in each program may reflect the demographics already served within that institution or the geographic community surrounding the hospital or health center, many other factors influence demographic composition. Factors affecting the demographic makeup of the populations seen by health care based programs include program specific outreach efforts and affiliations, cultural background of staff, and linguistically accessible services. For example, BIDMC’s Center for Violence Prevention and Recovery may serve a higher percentage of male survivors and the GLBT communities because of the hospital’s specific outreach and affiliation with GLBT-focused organizations. In addition, BIDMC’s Center serves victims of community violence, which includes more male survivors. While some patients and employees self-refer to programs, the majority of clients are referred by health care providers, making these demographics vulnerable to racial and other forms of bias in screening and assessment practices.

One common thread among the hospital-based programs is that they serve a diverse group of victims and survivors of violence. They tend to see some clients who have intermittent crises, and some who have multiple traumas, including acute and severe physical and sexual trauma. The Boston programs also see victims/survivors who have not identified domestic violence as the primary issue, yet the violence is impacting immediate safety and undermining their health and well-being. Many clients served by the Boston program are isolated, and may be more inclined to use domestic violence services in health care because of the accessibility and/or neutrality of the setting. These are clients who may not have had any contact with community-based programs, shelter or hotlines. They may not be ready to take action, engage law enforcement or the court system. Some clients may be embarrassed to call a shelter program, or need the security and privacy afforded in a health care setting in order to safely access domestic violence services. While shelters and domestic violence hotlines continue to provide critical emergency services for victims, placing domestic violence advocacy services within the health care setting offers additional avenues for help as well as for earlier intervention and prevention.

There are also many survivors of domestic violence using the Boston programs who are also connected to multiple resources in an effort to meet their needs. There are clients who use the services of multiple social service agencies, health care settings and Emergency Departments because their issues are complex and complicated. These clients may be coping with homelessness, mental health issues, poverty, addictions, and chronic health issues. They fall through the cracks of the “system” and may be difficult to engage on an ongoing basis. Many of these clients benefit from intervention and case management with a trauma-informed practitioner.

In settings where routine screening and assessment practices are established, some of the clients presenting to the Boston programs are in less acute situations. Unfortunately, many victims continue to come to our Emergency Rooms and Urgent Care practices having just sustained injuries resulting from sexual and domestic violence. Virtually all of our clients are dealing with the complicated and long-term impacts of protracted domestic violence, such as mental health effects, substance abuse, economic instability, and chronic pain from past injuries and abuse. Health care providers continue to have vastly differing skills and capacities to respond to domestic violence, making the work of health care-based DV and sexual assault programs critical.

Most programs are seeing predominately women who are victims of domestic violence. Among some of the hospital programs, they estimate that annually they see men in fewer cases. Some examples of annual percentages of men receiving services are as follows:

- Newton-Wellesley Hospital – between 5-8%
- Boston Medical Center – less than 1%
- Beth Israel Deaconess Medical Center – between 15-20%
- Massachusetts General Hospital – about 5%
- Brigham and Women’s Hospital and Faulkner Hospital – between 5-10%



## **4. Strategic Planning: Building and Sustaining the Work in Health Care**

### **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, where they were asked to consider the most important piece of advice they would give to new programs as they are starting their work in a health care organization. The following were their responses:

1. Define abuse and be clear about the scope of your program. Who will you serve? Do you have the capacity to respond? What resources do you need?
2. Be mindful of funding. Find ways to support and enhance community-based programs while seeking funding for the health care program. Build partnerships with community programs and leverage resources for the community as you pursue your funding. Understand your health care organization's development office. Know the channels for exploring funding options.
3. Find champions and allies within the health care program 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 health care 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 health care who have the investment, capacity and resources to work with you and your program.
  - c. Find internal leaders who are decision-makers and can support your program long-term, not just as you launch the new program.
  - d. Find champions within each discipline and department.
  - e. Know your allies, and expect friction/conflicts in some areas.
  - f. Be prepared to find unexpected allies in many disciplines and departments within health care. There are numerous people who are invested in helping, but they are not sure how to get involved, or haven't been asked to help yet.
4. Understand your institution's history in providing domestic violence responses – before the program was conceived.
  - a. Who owns the issue in the health care institution?
  - b. What are the policies and protocols?
5. Strategically locate the program in the division or department where you feel you will get the most support and visibility for the program. Likewise, consider the location of the office space for direct service staff/advocates. Sometimes there is little choice in this. Make the best use of the space, and ensure privacy and safety for both victims and staff.
6. Align your program with the mission of the health care 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 to "serve the community", "provide compassionate care", "provide exceptional care without exception," and/or "train the future leaders of health care."

**a. Sample Specific Start-Up Questions posed by the newest COBTH Domestic Violence/Sexual Assault Programs**

*Prepared by Erin Miller, Newton-Wellesley Hospital (NWH) and Joanne Timmons, Boston Medical Center (BMC)*

Introduction:

Erin Miller and Joanne Timmons started in their roles as Coordinators of their respective programs within six months of each other, and in preparing this manual, shared and compared their notes regarding their respective start-up questions, which were somewhat similar. They reflected on their many conversations with those in other hospitals as well as leaders within their own institutions, and have compiled a summary of some of their questions to share with others.

Several questions were about MA state laws, policies, and players which significantly influence the structure and practice of a hospital-based program. These questions included:

- What are the Massachusetts laws pertaining to domestic violence and sexual assault, both criminal and civil?
- What do the state's mandated reporting laws require/involve?
- What are the other relevant state laws pertaining to discrimination, immigration, emergency contraception, mature minors and medical care, etc.?
- How do the police, courts, and other systems handle DV cases, how accessible are interpreters, etc.?
- What constitutes victim 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) program and/or Children's Advocacy Centers, what are their protocols, where are the sites?

The next level of questions pertained to the culture, practices, structure, and general operations of their respective hospitals, and included questions such as:

- How is the hospital organized (org chart very helpful), who are the decision makers, and where does or will the DV/SA Program sit?
- What are the hospital's culture, mission, and priorities?
- Whom does the hospital serve? (i.e., demographics, medical specialties, etc.)
- What are the hospital's protocols for communications, such as materials development, information sharing, PowerPoint templates?
- What hospital policies currently exist relating to domestic violence (DV) and sexual assault (SA)? (both clinical and employee)
- What are the protocols for accessing various services such as interpreters, legal counsel, security, etc.?
- Do security staff have arrest powers? What is the relationship to local police?



- What systems and protocols are in place relating to medical record documentation, coding, access, etc.?

The third level of questions were more specific to the development and operations of the domestic violence and/or sexual assault program itself, as well as its relationship to other programs, providers, and disciplines within the organization. These questions included:

- What is the program model, structure, and scope of services?
- Will we serve patients, employees, and/or community members?
- How will referrals be made to the program, and from our program to other clinical areas?
- What is our role with regard to
  - Physicians?
  - Nurses?
  - Social Workers?
  - Affiliated satellite sites, outpatient clinics, and private practices?
  - Security?
  - Administration?
  - HR and EAP?
  - Child Protection Team (if available)?
  - Addictions and Mental Health Specialists?
  - IRB office and research development?
  - Development/fundraising efforts?
- What are best practice standards for record-keeping and information sharing, both within the Program and in relation to wider hospital practice?
- How is the program funded, what are the protocols and expectations regarding future funding, grant applications, etc.?

This is by no means a comprehensive list of all the questions that arose during program start-up, and this manual addresses many others that pertain to specific program operations, but may offer some food for thought for others in a position of creating a new program.

### **c. Aligning DV/SA Work with the Hospital/Health Centers' Missions**

In order to be effective, a hospital's domestic violence 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 domestic violence program director and staff should become well-versed in describing and giving examples of how the DV program's efforts support and contribute to the hospital's overall goals and mission. The program should assist others who speak on behalf of the hospital (Development, Corporate Communications, etc) in doing the same. The more DV efforts can be visible and viewed as a critical and supporting piece of a larger mission (rather than as an add-on or unrelated effort), the more buy-in there will be throughout the health care organization. This will encourage health care professionals to become involved and participate in the DV program's efforts.

#### Boston Medical Center (BMC) Example

BMC prides itself on its mission of providing "exceptional care without exception." The efforts of the DV program support the hospital in carrying out this mission by providing even more

specialized services and holistic care. The DV program enables the hospital to better address many of the barriers to care that survivors face, such as little or no health insurance, inability to pay for services that are not covered, undocumented legal status, complex mental health and social challenges, etc.

BMC articulates its performance goals in terms of VSSC- Volume, Safety, Satisfaction and Cost. For each of these goals there are measurable and closely-tracked data points, and specific targets for each that vary by year. For example, last year, the safety goals related to hand washing. This year, they relate to patient vaccinations. While DV efforts may not be directly related to these specific goals, the overall efforts and rationale for a DV response tie very closely to the overall goals of the hospital, which include maximizing health and safety for patients and staff, while minimizing liability risk .

Finally, the work of the DV program at BMC is closely tied to the larger medical practice philosophy of "first do no harm", demonstrating wherever possible how the trauma-informed practices that are recommended by domestic violence experts will prevent the inadvertent cause of harm.

#### **d. Family Violence Prevention Fund's Business Case and Public Health Tool Kits**

As the Boston programs have developed over the years, one essential resource has been the [Family Violence Prevention Fund](#). The Fund has extensive materials online. The Fund also employs a brilliant and generous staff who can provide guidance and networking as you think about your own institution. Its National Health Resource Center on Domestic Violence provides free technical assistance, along with outreach and education materials and guidelines for addressing domestic violence in health care settings.

Two important references to highlight are as follows:

- The [Business Case for Domestic Violence Programs](#) in health care developed by the Fund and Physicians for a Violence-Free Society.

The Business Case includes a PowerPoint Presentation developed for health care decision makers and administrators, and a Return on Investment Tool to analyze the cost and benefits of implementing domestic violence programs in health care.

- [Making the Connection: Intimate Partner Violence and Public Health](#) - PowerPoint presentations by Dr. Linda Chamberlain.

This evidenced-based training tool presents promising practices and the health impacts of domestic violence. It is intended to engage health care providers and leaders in the public health arena in responding to domestic violence.

Many of the Boston programs use these and many other materials from the Fund as templates for training and in strategic developing their programs within their health care organizations.

### e. Domestic Violence Leadership Teams in Health Care Organizations

The following table provides information about the leadership teams within 7 health care-based domestic violence and sexual assault programs, including Faulkner Hospital - Passageway, Newton-Wellesley Hospital (NWH) – Domestic Violence and Sexual Assault Program, Boston Medical Center – Domestic Violence Program, Boston Area Rape Crisis Center (BARCC) – Medical Advocacy Program, Brigham and Women’s Hospital – Passageway, Massachusetts General Hospital – HAVEN, and Beth Israel Deaconess Medical Center – Center for Violence Prevention and Recovery. The teams have similar purposes and goals. They may differ in members, agendas and frequency of meetings.

Leadership Team Examples:

<b><u>Institution</u></b>	<b>a. Purpose/Goals</b>	<b>Members</b>		
<b>Name of Leadership Team</b>	<b>b. Typical Agenda</b>	<b>Leadership from....</b>	<b>Frequency</b>	<b>Facilitator</b>
<b><u>Faulkner Hospital</u></b>				
Domestic Violence Advisory Council	a. Strategic planning; Feedback on challenging issues; Ideas for program development; Program updates b. Agenda is a forum for group feedback, work/task-focused to plan hospital-wide events, and share information.	Vice President, Service Excellence Vice President, Professional Services Social Work Nursing Chaplaincy Security Education Department Community Benefits Psychiatry Human Resources	2-3 times annually	Domestic Violence Program Coordinator

<b><u>Institution</u></b> Name of Leadership Team	<b>a. Purpose/Goals</b> <b>b. Typical Agenda</b>	<b>Members</b> <b>Leadership from....</b>	<b>Frequency</b>	<b>Facilitator</b>
<b><u>Newton-Wellesley Hospital</u></b>  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
<b><u>Newton-Wellesley Hospital</u></b>  Domestic Violence/ <b>Sexual Assault Program</b> 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

<b><u>Institution</u></b> Name of Leadership Team	<b>a. Purpose/Goals</b> <b>b. Typical Agenda</b>	<b>Members</b> <b>Leadership from....</b>	<b>Frequency</b>	<b>Facilitator</b>
<b><u>Boston Medical Center</u></b>  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.	Physicians in Adult and Pediatric practices Nurses Public Safety Human Resources Legal/General Counsel Social Workers from different clinical areas Interpreter Services Child Witness to Violence Project Medical Legal Partnership – Boston Pastoral Care Community partners include the Northeastern University School of Law Domestic Violence Institute, and the Boston Area Rape Crisis Center	Quarterly	Domestic Violence Program Coordinator
<b><u>Medical Advocacy Program</u></b> <b><u>Boston Area Rape Crisis Center</u></b>  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

<b><u>Institution</u></b> Name of Leadership Team	<b>a. Purpose/Goals</b> <b>b. Typical Agenda</b>	<b>Members</b> <b>Leadership from....</b>	<b>Frequency</b>	<b>Facilitator</b>
<b><u>Brigham and Women's Hospital</u></b>  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
<b><u>Massachusetts General Hospital</u></b>  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

<b><u>Institution</u></b> Name of Leadership Team	<b>a. Purpose/Goals</b> <b>b. Typical Agenda</b>	<b>Members</b> <b>Leadership from....</b>	<b>Frequency</b>	<b>Facilitator</b>
<b><u>Beth Israel Deaconess Medical Center</u></b>  Domestic Violence Advisory Council	<p>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.</p> <p>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.</p>	<p>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</p>	<p>Quarterly  --frequency to be determined when group resumes</p>	<p>Director of the Center for Violence Prevention and Recovery</p>

Program leaders shared these additional comments and suggestions about leadership teams:

- Be clear about the purpose of the leadership team, and invite members, rather than keeping the team open-ended or having people sign-up. (You can create different opportunities for staff members who would like to volunteer -- such as domestic violence awareness activities and attending events at community-based events.) While it is valuable to invite health care professionals who already understand the issues and have a level of investment in the domestic violence/sexual assault program, it is also important to be strategic about cultivating members who may not yet be involved, yet are decision-makers and leaders in their respective clinical or administrative areas.
- The meeting agendas need to be purposeful, clear and efficient. Although many programs use the meetings to update their teams about their programs, there should be a clear action plan and mechanism for the members to advise and become involved in efforts during the scheduled meetings and in between meetings.
- As you will note in the following table, the BARCC Medical Advocacy Program's leadership team is comprised of community partners with multi-disciplines given its purpose.
- The NWH Domestic Violence and Sexual Assault Program has intentionally built two leadership teams into its program. One group is comprised of health care professionals from the hospital, while the second group is comprised of community members. This raises an interesting conversation among the hospital-based programs about their goal to include community members and survivors in the leadership teams. It has been challenging to accomplish this in the same group as the community members may be marginalized and feel less comfortable informing health care operations. Likewise, health care providers may defer to community members and survivors as the "experts" and not take ownership of the group. NWH provides a helpful model in this arena.



## **f. Funding Strategies and Resource Sharing with Community-Based Programs**

Since the inception of the Boston programs, there has been clear articulation about the need for health care organization to “own” the issues of domestic violence and sexual assault as health care issues, and in turn, provide adequate funding in order to respond to these issues. Inevitably, funding has been a complicated issue, with health care organizations doing the best they can do given the realities of their budgets at different times.

In general, the Boston hospitals have prioritized funding for their in-house domestic violence and sexual assault programs, while also supporting community based programs in a number of ways. For example, the health care programs have been extremely cautious about applying for public and private funds that would compete with or potentially jeopardize community-based services. In addition, when private or public funds have been sought by health care organizations, there has been clear collaboration and resources-sharing with community partners. In Massachusetts, state and public agencies have crafted grants in order to ensure that the continuum of services – especially the community-based resources – are well connected and coordinated. This has been especially important in creating and reinforcing meaningful collaboration to serve the needs of victims/survivors. Hospitals and health care systems have provided sponsorship to community-based programs’ fundraising events and activities. They have offered community programs use of meeting space at no charge, as well as tangible donations, such as volunteer time, gift cards for shelter guests and furniture. In addition, the Boston programs have offered access to free continuing education and training sessions to community program staff.

Lastly, the COBTH DVC group as a whole, and individual member programs have advocated for funding for important community-based and statewide programs by writing letters of support (Example: [COBTH letter on SANE](#)).

## **5. COMMUNITY LINKAGES**

### **a. Importance of Community Linkages**

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

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

The DVC leadership wrote the following document in 2005 to facilitate a discussion between health care domestic violence programs and community programs. It outlines some ways in which the health care programs can offer support to their community partners.

## **Conference of Boston Teaching Hospitals Domestic Violence Council**

### **Collaboration with community-based domestic violence and sexual assault programs**

The Conference of Boston Teaching Hospitals (COBTH) Domestic Violence Council's mission is to promote greater sensitivity and responsiveness on the part of our teaching hospitals to domestic violence and abuse. The Domestic Violence Council (DVC) was created by the CEOs at COBTH hospitals in 1995 to address the issue of domestic violence. After conveying a year-long Task Force studying multiple aspects of this serious problem, the Council made a series of recommendations on how the Boston teaching hospitals could raise domestic violence awareness at all levels of their institutions through training, policies, and protocol development, patient care and employee initiatives, collaboration and communication among Boston hospitals, and strong partnerships with community organizations and governmental agencies.

Currently, the DVC includes representation from 12 COBTH hospitals and 9 key community and governmental organizations. The council's membership is active with monthly meetings covering a wide range of issues. Members strategically review trends in the field, discuss domestic violence policy development and programming at the individual member sites, and identify gaps in services and priority areas for shared work.

Many Boston area hospitals and health centers have on-site programs, advocates and/or staff dedicated to addressing domestic violence and sexual assault. It is our intention to provide support to community-based programs to strengthen their ability to access funding necessary to continue vital services, such as 24-hour hotlines, emergency shelter, safety planning, and advocacy. To that end, members of the COBTH DVC have discussed ways in which health care programs might collaborate with community-based programs. This following summarizes DVC members' ideas:

- ♦ **Assistance to domestic violence victims/survivors in accessing and navigating the health care system.** Community-based programs may call health-care programs to identify health care providers, including primary care, OB/GYN care, specialty care, mental health and addiction services. When a participant/guest in a shelter, safe bed or transitional housing program needs to go to a hospital or a health center, on-site programs can provide support to the individual while she/he is in the health care setting, and coordinate care with the community-based program.
- ♦ **Increasing safety for victims/survivors.** Health-care programs work to increase safety for individuals while they are receiving their health care. This often involves providing consultation and education to health care providers about how to effectively address abuse in

the delivery of medical or mental health care. When a survivor in a community-based program has safety concerns related to her/his care, health-care programs can facilitate connections with the appropriate health care staff to address the concerns.

- ♦ **Ongoing advocacy services to victims/survivors.** Health-care domestic violence programs have advocates who provide ongoing support, counseling, support groups and safety planning to individuals. Community-based programs can refer eligible individuals for these services.
- ♦ **Health education and promotion.** Health-care programs have access to information about numerous medical conditions and health concerns that may be helpful to staff and/or participants/guests at community-based programs. The information may be shared in written materials or through an arranged workshop or presentation by a health care provider.
- ♦ **Networking and resource sharing for staff.** Health-care program staff often sponsor trainings and in-service sessions that could be open to community-based program staff. Likewise, we could create a mechanism for sharing resource information and trends in the field to enhance everyone's ability to respond to victims/survivors' needs and strengthen working relationships. With networking and resource sharing, we can better assess and address gaps in services.
- ♦ **Collaboration on education and prevention efforts.** All of the health-care programs have training components and/or provide staff training. Collaboration with community programs would enhance training and outreach efforts. Additionally, with the movement in the field toward prevention, we can work together to maximize our resources on program planning.

### c. Examples of Current Community Collaboration and Projects

The health care domestic violence and sexual assault programs have developed and nurtured effective community partnerships that address the complex needs of victims/survivors. The following is a partial list brainstormed by COBTH DVC members about the collaborations between health care and community providers currently occurring in the greater Boston area. Please contact the [programs](#) directly if you are interested in learning more about any of these partnerships.

- Center for Violence Prevention and Recovery and the Jewish Coalition Against Domestic Violence;
- Center for Violence Prevention and Recovery, HAVEN, BMC's Domestic Violence Program and Passageway are all active members of the Boston Regional Domestic Violence Providers Group;
- Many members of the COBTH DV Council are also members of Jane Doe Inc. (the Massachusetts Coalition Against Sexual Assault and Domestic Violence);
- The Passageway Health Law Collaborative between Passageway, and the WilmerHale Legal Services Center of Harvard Law School;
- Lahey Clinic and SAHELI – Friendship for South Asian Women;
- Lahey Clinic and REACH, a community based domestic violence agency.

- HAVEN and a local non-profit, Regaining One's Self Esteem (ROSE) Fund which helps survivors receive free corrective medical and dental procedures and surgeries for IPA related injuries;
- Community Advocacy Program and Greater Boston Legal Services;
- Boston Area Rape Crisis Center and the Massachusetts Bay Transit Association ( MBTA) in a public awareness campaign about sexual violence;
- Boston Area Rape Crisis Center and HarborCOV, a community-based domestic violence agency;
- Faulkner Hospital and SAGE-Boston, and the DOJ Abuse in Later Life Training Grant for Law Enforcement;
- Faulkner Hospital and the Roslindale Neighborhood Coalition against Domestic Violence.

#### **d. How Health Care Can Support Community Agencies in Tangible Ways**

The Boston programs are deeply invested in supporting community partners and the clients that they serve. This commitment can be observed in collaboration in direct service delivery, as well as in programmatic support. For example, advocates from community programs and advocates from health care programs have co-led support groups. Likewise, hospitals have provided free space for community programs to offer educational workshops.

As another expression of the commitment to community partners, the Boston programs have created opportunities to share resources and tangible financial assistance. For example, funding proposals developed by the programs have been crafted to include support for community partners. The Boston program directors have facilitated and/or endorsed the community's request for hospital sponsorship of fundraising events. The programs have sponsored hospital and health center drives for curtains, toiletries, groceries and other necessities for emergency shelters.

#### **e. Examples of a Medical-Legal Partnerships**

##### **Boston Medical Center (BMC) and the Northeastern University School of Law – Domestic Violence Institute (NUSL DVI)**

Although Boston Medical Center's formal Domestic Violence Program is relatively new, advocacy work with victims of domestic violence has occurred in the BMC Emergency Department since 1992, through a unique collaboration between the Northeastern University School of Law Domestic Violence Institute and an Emergency Room physician at BMC. As the Boston programs have learned over the years, not only do many survivors seek care for injuries and other acute violence-related health conditions in the ED, they are also more likely to connect with resources that are available on-site and at the time they seek care. Ever since its inception, law students and attorneys affiliated with the NUSL DVI have been on-site providing crisis intervention, legal advocacy (particularly related to restraining orders), and connection to community resources to patients who disclose intimate partner violence and are open to assistance. Additionally, the program has continued to serve as an important community partner as BMC has expanded its commitment and capacity to respond to domestic violence across the

entire hospital setting, offering critical legal advocacy resources to both patients and employees seeking assistance from the BMC Domestic Violence Program.

### **The Passageway Health-Law Collaborative (PHLC): Brigham and Women's Hospital and Harvard Law School's WilmerHale Legal Services Center**

The Passageway Health-Law Collaborative is a unique legal services partnership within a health care domestic violence program and in partnership with a clinical legal services center of Harvard Law School. By conducting a full legal assessment for victims, Passageway helps victims to move beyond legal crises and identifies ways that lawyers can be proactive in their assistance with issues such as health care proxies, disabilities, insurance, access to systems and rights, housing and tenant problems, financial issues, guardianship and permanency planning for children, and others. A streamlined intake and screening process was designed through the PHLC. Legal services staff and domestic violence program staff work closely to coordinate services for victims and survivors.

## **6. Increasing Knowledge, Awareness and Skills related to DV in Health Care**

### **a. Overview**

One of the strengths of the COBTH DVC is its members' generosity in sharing their materials. Ideas, approaches to training health care providers, and PowerPoint presentations are readily exchanged, with such disclaimers as: "This approach worked for me, within my setting...with this specific group of providers." and "I only had 15 minutes at a staff meeting to get my point across, so here's what I said." The concepts of proprietary ownership and intellectual property seem less relevant when the take-home messages are about how to safely intervene with domestic violence, and prevent human tragedy. While each of the Boston programs maintains its own "case vignettes" and has its own creative approaches to engaging health care providers, the group shares the goal of improving health care's response to domestic violence and sexual assault.

### **b. Education and Training Strategies**

General strategies to consider when developing a training program are listed:

- Integrate, integrate, integrate! Get to know the education departments and training directors throughout your health care organization. Find ways to integrate content about domestic violence and sexual assault into the existing curricula and training structure of the institution.
- Develop a training/awareness strategy that is realistic and matches the existing capacity within your organization. First, make sure that you have a plan in place to respond to an increase in identification of abuse before you begin training. Make sure that you include the institution's response plan in all of your training materials.
- Be flexible, and work toward incremental-change. It will take time to figure out a good strategy, and to implement it. Be intentional and clear about your goals.

- Be a good advocate while you are training. You may need to use different words and language to appeal to your audience. You do not need to change your underlying message or compromise your expertise or integrity, but may need to put it in a context that resonates with your audience.
- Consider adopting a training model where you co-present with a provider who represents the department or division in which you teach.
- Members have benefitted from attending national conferences and reviewing a wide variety of training materials on domestic violence and sexual assault. The Family Violence Prevention Fund is an excellent resource for which the Boston programs are incredibly grateful.
- Tailor everything you present to personalize the issue to your health care organization. For example, citing the literature and prevalence statistics are important to a certain extent. More importantly, health care providers want to know how this issue affects the patients that they see every day in their own settings.
- Define 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 chart reviews are additional measures to evaluate knowledge and intervention skills.
- Offer continuing education credits as much as possible to increase attendance. Offering breakfast and lunch are also helpful benefits to encourage participation by busy health care providers.
- 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 might distinguish that an adequate training on domestic violence/sexual assault intervention requires a longer duration, and typically occurs over multiple sessions due to time constraints. Effective training includes measurable goals related to change in participants’ knowledge, attitudes and/or skills.

Collectively, the Boston programs have provided training sessions to virtually every discipline, type of provider and staff person within health care.

### **c. Disciplines Trained**

Training and educational sessions have occurred within the following health care departments and clinical areas:

- |  |   |
|--|---|
| • OB/GYN                                       | • Emergency Department                                |
| • NICU   | • Behavioral Health                                   |
| • Support Staff                                | • Nursing   |
| • Primary Care                                 | • Infectious Disease Clinic staff                     |
| • Physical therapy                             | • Medical Legal Partnership                           |
| • Medical Residents (in a variety of settings) | • Social Work   |
| • Admitting Staff                              | • Case Management                                     |
| • Chaplaincy and Pastoral Care                 | • Patient Family Relations                            |
| • Psychology and Psychiatry Residents          | • Child Witness to Violence Project staff and interns |
| • Medicine                                     | • 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
- Employee Assistance Program
- Orthopedics
- Environmental Services
- Food Services
- Hospital Leadership – Senior Management, Board of Directors

#### **d. Training Topics**

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

- Intersections of Domestic and Sexual Violence (D/SV) & Addictions
- D/SV & Pregnancy
- Intersection of D/SV & LGBTIQ Communities
- Intersections of DV & Physical Disability
- 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
- Trafficking
- Basics of Intimate Partner Abuse/DV 101
- Teen Dating Violence
- 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
- 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

## e. Sample Slides

Example of PowerPoint presentations are included in PDF format and can be accessed through the links below:

[HAVEN at MGH - Is your relationship affecting your health?](#)  
[Brigham and Women's Hospital – Domestic Violence and Healthcare, the Current Climate](#)

## f. Online Education and Resources

As many educational requirements for health care providers have moved online, the Boston programs have worked to create their own courses and/or edit content on existing online courses. For example, for many years, Brigham and Women's Hospital had its own online course, which included all forms of abuse. As the hospital changed vendors, it allowed for the conversion of its own course, and added options for the vendor's existing courses which were more specific to domestic violence.

As House Officers manuals and resources are often located on the hospital's internal and external web pages, the programs have worked to make sure that relevant content on DV/SA issues is included. As much as possible, the program's webpage will include important educational content.

For example, the Center for Violence Prevention and Recovery includes the following description of the obstacles to leaving an abusive relationship.

### Obstacles to Leaving an Abusive Relationship

**Often people ask "Why does the person being victimized stay?" Listed below are some obstacles to leaving an abusive relationship.**

**Fear:** Many people who are victimized fear that their partners will harm them if they attempt to leave. Victims also fear not knowing what kind of future lies ahead, and some fear being alone.

**Threats:** Most people who are victimized are threatened by their abusive partner and fear that leaving will increase the risk of violence.

**Financial Constraints:** Many people who are victimized, especially those with children, are financially dependent on their partners, sometimes because their partners have not allowed them to work.

**Lack of Support:** Not all people who are victimized have family and friends who support their decision to leave. Some victims are so isolated by their abusive partners that they have no support system whatsoever.

**Lack of Knowledge about Rights and Options:** Not all people who are victimized are aware that there are community agencies that can help them get to safety and rebuild their lives.



**Family Pressure:** People who are victimized are often blamed by their family for the violence occurring, and are sometimes told to make the relationship work rather than separate from their partners.

**Societal Pressure:** Traditional notions of men and women's roles, combined with the stigma of divorce and separation, can make the decision to leave that much harder for people in abusive relationships.

**Children:** Many people who are victimized don't leave their batterers because they want their children to have a relationship with the other parent. Other people worry that they won't be able to provide for their children if they leave.

**Love:** Many people who are victimized feel an emotional attachment to their batterers and cling to the hope that things will get better. They may also feel like they have failed to keep the family together.

#### **g. Awareness Month Activities**

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. Many COBTH programs use these months as an opportunity to sponsor programs and events to educate and raise awareness of domestic violence and sexual assault.

#### **i. Domestic Violence Awareness Month**



Most health care programs use DVAM as an opportunity to sponsor Medical or Nursing Grand Rounds, or create another training forum for health care 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 victims 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.
- The Center for Violence Prevention and Recovery 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 Clinic completed an online domestic violence training for all employees. There was one version for clinical/direct care staff and another version for other hospital employees.
- Passageway at Brigham and Women's Hospital has created a spiritually-focused forum called "Honoring Survivors" which occurs annually and reaches health care providers and hospital staff. Last year, Passageway created the [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. The staff engaged in three weeks of activities:  
Week 1: Silent Witnesses Display  
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 campaign, "Love Should Not Hurt." Faulkner Hospital used the summer months to do a toiletry drive for a local domestic violence shelter and create awareness about the needs of victims, and the BMC Domestic Violence Program coordinates a holiday gift drive in support of a local shelter program each year.



## ii. Sexual Assault Awareness Month

- The Boston Area Rape Crisis Center sponsors an annual walk to raise awareness and promote community involvement in fundraising for its services. The COBTH DVC members have participated in this walk.
- The Center for Violence Prevention and Recovery has worked on the [Clothesline Project](#) with BARCC, and has displayed some of the t-shirts.

## 7. Program Evaluation and Research

The Boston programs have worked hard to develop outcome measures for their domestic violence programs. This continues to be a work-in-progress, as the tangible measurements of “client success” are debatable. The program leaders have worked closely within their health care 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 a unique data collection form which is considered to be part of the program’s operations, rather than clinical data. The form records basic demographic information as well as information about the types of abuse/violence experienced by the client. The forms are used for operational purposes, and to gather aggregate data to report back to funders.

### b. Client Feedback Form

The Domestic Violence Program Client Feedback Form or “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 the Boston area: the AWAKE Project at Children's Hospital, the Center for Violence Prevention and Recovery at Beth Israel Deaconess Medical Center, the Community Advocacy Program of CCHERS, Inc., and HAVEN at Massachusetts General Hospital. Other members of the COBTH Domestic Violence Council also provided guidance in the development of the form, which was developed between 2002 and 2006.

The Client Feedback Form was created to address the lack of client progress measures designed for use in healthcare-based domestic violence advocacy programs. The Client Feedback Form was developed with input from healthcare-based DV program directors, advocates and clients. Other resources used when creating the form included prior research findings, DV program intake and activity forms, and other outcome measures, including the DV Survivor’s Assessment (DVSA), one of the only other progress measures designed for use with domestic violence survivors.

The Client Feedback Form may be used to facilitate advocacy work with clients and to evaluate 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 of partner abuse 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](#)

## **Program Outcomes**

HAVEN has been utilizing the Client Feedback Form (CFF) to collect information from its clients about the effectiveness of advocacy and counseling with the program with the following results:

- Ninety-five percent of clients surveyed said that their understanding of partner abuse was better.
- Eighty-seven percent reported that their personal safety was better after a series of meetings with an Advocate.
- Seventy-six percent of clients report they feel better about themselves overall.
- Fifty-eight percent said their physical health was better after being connected with a HAVEN Advocate.
- Forty-two percent reported their housing situation was better and the same amount felt better about their finances and work, which is remarkable given the very difficult economic times of the past year.

### **c. Delphi Instrument**

The Delphi Assessment tool, developed by [Dr. Jeffrey H. Coben](#) has been used by some of the Boston programs in a number of ways. For those unfamiliar with the tool, a description can be found on the [Agency for Healthcare Research and Quality \(AHRQ\) website](#) at:

The Agency for Healthcare Research and Quality (AHRQ) developed a consensus-driven quality assessment tool for evaluation of hospital-based domestic violence programs. While serving as AHRQ's Domestic Violence Senior Scholar-in-Residence, Dr. Jeffery H. Coben developed the instrument based on the views of national experts who took part in an AHRQ-funded Delphi process. The Family Violence Prevention Fund co-sponsored Dr. Coben's position.

The experts achieved consensus on 37 performance measures, which have been expanded into a working instrument. The measures are in the form of questions, each with a list of possible responses and associated numeric scores for each response.

The Boston programs have used the tool to get a baseline for their respective healthcare organization. They have used it to assess their current programs. In addition, they have used the framework presented in the instrument to educate health care providers and hospital administrators about the components necessary to develop comprehensive domestic violence programs.

### **d. Balanced Scorecard**

Some of the Boston programs have used chart audits to review compliance by health care providers to screening and assessment protocols. Chart audits have revealed screening rates as well as identification rates of domestic violence. In addition, chart audits have reviewed documentation standards, and raised issues requiring quality improvement.

As the Balanced Scorecard is used, it presents opportunities for more oversight and accountability in reviewing domestic violence and sexual assault interventions.

#### **e. Surveys**

The Boston programs have used numerous surveys to elicit provider feedback on advocacy services and to measure domestic violence and program awareness among providers and health care organization employees. Additionally, programs have used surveys to capture client satisfaction and experiences. For example, Boston Medical Center is using the following satisfaction survey ([English Version](#), [Spanish Version](#)) with its clients. The advocate gives clients the survey along with a self-addressed stamped envelope and explains that it will be sent to her supervisor, allowing clients to choose whether or not to complete the form, and to answer honestly and anonymously if they do.

## **f. Process Data Collection**

The following examples of service delivery in FY2009 are intended to share information about the types of data collected. The information is not meant as a comparison among health care institutions. The patient volume at each institution differs as well as the staffing and capacity to respond to all of the potential victims/survivors who come into each setting.

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

In FY 2010, the Center served 455 clients, 317 of whom were new to the program and 138 were ongoing from the previous fiscal year(s). The types of crime experienced by the clients were:

Domestic Violence 50%  
Sexual Assault 30%  
Community Violence 20%

#### **Ages Served:**

12-17 1.7%  
18-24 18%  
25-59 65%  
60-74 5%  
90 + .3%  
Unknown 10%

#### **Gender:**

Female 80%  
Male 9%  
Trans .6%  
Unknown 9%

#### **Race:**

Asian 5%  
Black 18%  
Latino 9%  
White 46%  
Others 2% (Cape Verdean, Haitian,  
Multi-Racial, Hawaiian/Pacific Islander)  
Unknown 20%

### **Massachusetts General Hospital – HAVEN**

In FY2009:

HAVEN received 377 referrals, 43 percent from MGH Boston, 17 percent from MGH Chelsea, 10 percent from MGH Revere and 19 percent from the community

- 75 percent of clients had children
- 95 percent reported emotional abuse, 78 percent reported physical abuse, 26 percent reported sexual abuse
- 32 percent of clients reported that the abusive partner made threats to kill client
- HAVEN provided services to 665 unique clients. HAVEN advocates provided 4,313 client-specific activities and 1,890 in person individual sessions with clients
- A HAVEN Advocate met with 29 adolescents at the Revere Adolescent Health Clinic

### **Brigham and Women's Hospital and Faulkner Hospital – Passageway**

During FY2009, Passageway responded to a total of 992 individuals experiencing domestic violence and provided 13,102 service contacts on behalf of all individuals assisted at BWH, FH and SJPHC. Services included advocacy and counseling (26 percent), outreach and follow-up on cases (23 percent), and provider consultations (51 percent). This year's data represents a three

percent increase in individuals served as compared to FY2008. Ninety-six percent of the clients were women, three percent were men, and one percent unreported. The demographics of our clients are as follows:

- Race: 2 percent Asian, 25 percent Black, 23 percent White, 37 percent Latino, 0 percent Native American, 1 percent other, 12 percent unknown
- Language: 73 percent English, 22 percent Spanish, 2 percent other, 3 percent unknown
- Age: 5 percent teens, 26 percent twenties, 23 percent thirties, 18 percent forties, 10 percent fifties, 6 percent sixty and above, 12 percent unknown

### **Boston Medical Center**

From January to December of 2010 (the Domestic Violence Program's first full year with direct advocacy services data), BMC's Safety and Support Advocate served 130 unique clients, both in person and over the phone. The services and other types of advocacy the program provides include crisis intervention/safety planning, counseling, many types of personal and systems advocacy, emergency financial assistance, transportation, cell phones, assistance with victim compensation, and facilitated referrals to shelter and to many other community resources. A significant percentage of these survivors have become "on-going" clients, requiring intensive follow-up and support with many complex needs. The total number of points of contact/service with both new and ongoing clients was just over 1,000 for the year.

Descriptive demographics of the clients served by BMC's DV Program during 2010:

#### **Gender:**

- Female: 98%
- Male: 1%
- Transgender FTM: 1%

#### **Age:**

- under 18: 1%
- 18-24 years: 20%
- 25-59 years: 77%
- 60 or older: 2%

#### **Race:**

- Black: 36%
- Latino: 39%
- White: 25%
- Unknown: 8%
- Three women identified as Cape Verdean, two as Moroccan, one as Nigerian, one as Haitian, and one as American Indian/Alaskan native.

#### **Disability:**

- 63% of clients had a known physical or mental disability.



## 8. Advocacy Services within Health Care Organizations

### a. Overview

There are many benefits of having domestic violence and sexual assault advocates within a health care team. Beyond the requirements by the Joint Commission ([click here for details](#)) and other accrediting agencies, the integration of advocacy services in health care provides an opportunity to make a critical impact in people's lives. The existence of programs supports providers and increases their comfort when asking about domestic violence, offering an accessible, on-site response if domestic violence is identified or disclosed. One CEO of a Boston-hospital stated at a public forum that providing domestic violence services was just as important as providing cardiac surgery at his institution. He noted that health care institutions have a responsibility to address needs of victims of domestic violence because it is about providing "quality and comprehensive health care."

Victims who may not be ready to access shelters or hotlines may still seek health care. As health care professionals become skilled in routinely screening for and identifying domestic violence, victims may benefit in numerous ways. First, the act of domestic violence screening in itself is an intervention and informs patients that health care providers are concerned about their safety and well-being. Second, the screening process and availability of an on-site domestic violence program offer victims access to services in a setting that is convenient to where they receive the rest of their care. If a patient discloses abuse, their health care provider can refer them immediately to the domestic violence program for safety planning and ongoing support. Third, employees can find easy access to assistance within their workplace, if desired.

### b. Service Models that Differ from Boston programs

It is important to note that throughout Massachusetts and in other states, there are different models of domestic violence and sexual assault programming in health care settings that are extremely effective. For example, North Shore Medical Center, outside of Boston, operates [CrossRoads](#), a comprehensive advocacy services program of a community-based domestic violence program that is located within the health care setting. Holy Family Hospital, north of Boston, runs the [Family Safety Project](#), which includes a batterer's intervention program and services for children. Although this manual does not describe these programs fully, they are valuable resources with service models that work within their respective health care organizations and communities.

### c. Descriptions of Services

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

A number of programs' brochures and/or WebPages can be accessed by clicking on the name of the program or document in [Appendix A](#) and [Appendix B](#). Three program descriptions examples are included below:

- Boston Area Rape Crisis Center - Medical Advocacy Program**  
 BARCC Medical Advocates are certified rape crisis counselors who respond to hospital emergency rooms to provide information and support to sexual assault survivors and/or family members. Advocates provide support throughout the entire forensic exam if the survivor wishes. They can also be helpful with safety planning, arranging transportation, and with follow-up plans. In the immediate aftermath of rape, survivors face a host of emotional, medical, and legal decisions. An advocate can provide information to assist the survivor (and her/his family) in making the best possible choices. Research has shown that survivors who have a rape crisis advocate present at the hospital are more likely to feel positive about the experience of going to the hospital. This is an important start to the healing process.
- Boston Medical Center**  
 Boston Medical Center's Domestic Violence Program works to improve and coordinate the institution's response to domestic violence through training, education, and awareness, policy and protocol development, consultation and technical assistance, direct advocacy/support and connections to community resources. Direct services are provided by the Program's Safety and Support Advocate include crisis intervention and supportive counseling; risk assessment and safety planning; assistance with obtaining restraining orders, victim compensation, and a wide range of additional resources and benefits; accompaniment to court and other appointments; advocacy with a wide range of legal, medical, housing, and other systems as needed; on-going safety planning and identification of additional advocacy needs and resources.
- Brigham and Women's Hospital**  
 Passageway provides free, voluntary, and confidential services to patients, employees, and community members who are experiencing domestic violence. Services include risk assessment and safety planning, crisis intervention, individual counseling, support groups, referrals, intervention with complex systems (e.g., health care, courts, employers), as well as assistance in accessing resources and education to enable victims/survivors to understand their rights and options. Passageway advocates offer consultation to health care providers and hospital staff regarding screening practices, safety planning, culturally appropriate interventions, and other issues impacting patient and employee health and safety.

#### **d. Definition of Abuse**

Regardless of when they were created, all of the programs in health care continue to find it necessary to define domestic violence within their institutions, at times refining those definitions as questions arise. 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 definition may be stated in policies, trainings and/or in daily practice. Further in this document, there is a section about how to think about the response to types of abuse that falls outside of the 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, domestic violence programs may be able to assist and can offer important consultation and guidance on how to access other resources.

It is important to think carefully about the scope of your program and the definition you use to define domestic violence. Two Boston programs, Center for Violence Prevention and Recovery at Beth Israel Deaconess Medical Center and the Domestic Violence and Sexual Assault Program at Newton Wellesley Hospital, are dual programs, responding to both domestic violence and sexual assault.

The Boston programs use slightly different words to describe domestic violence, although they share similar concepts. The definition used by the Center for Violence Prevention and Recovery at BIDMC is comprehensive and is echoed by the other health care DV programs:

“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. Although the vast majority of abusive relationships involve some form of violence, it is often the emotional abuse that has the most devastating impact on a victim. Although women are more likely to be victims of domestic violence, anyone can be a victim of domestic violence including those in the GLBT communities, men, disabled persons, seniors, and elders.”

Most of the programs frame their definition by stating that there are health effects of domestic violence. One program, HAVEN at Massachusetts General Hospital developed a campaign called “Is your relationship affecting your health?” HAVEN developed materials to describe the many ways in which abuse, control and fear impact a person’s health and well-being. [HAVEN’s comprehensive brochure](#), which includes education for both survivors and health care providers.

Passageway at Brigham and Women’s Hospital also put its definition in the context of health impacts:

“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 health care.”

Like the other programs, Boston Medical Center includes in its definition a connection to health along with a statement that anyone is vulnerable to abuse:

“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.”

In terms of defining sexual assault, some programs include it in their definition of domestic violence, while others use the Commonwealth of Massachusetts definition, which states:

“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”

Newton-Wellesley’s dual program states in its definitions:

“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.

Domestic violence is a pattern of coercive, manipulative and/or controlling behaviors that serves to isolate or instill fear.

Sexual assault may include any or all of the following:

- Forced participation in unwanted sexual activities.
- Refusal to practice safer sex.
- Using alcohol and/or other drugs to make someone vulnerable to assault.
- Making public or threatening to make public your sexual history.
- Refusing to respect your sexual orientation and/or gender expression.
- Refusing to honor previously agreed upon boundaries of sex play.
- Forced use of pornography.”

## **e. Challenges of Providing Advocacy Services Within the Health Care Setting**

This next section will review some of the challenges involved in addressing domestic violence in health care organizations. The lessons learned and questions we continue to ask about key topics are presented in the following order:

- The Medical Model
- Family-Centered Care
- Health Care Settings as Public Places with Open Access
- Non-Intimate Partner Violence
- Mandatory Reporting
- Expert Witnesses and Handling Subpoenas
- Employees Experiencing Domestic Violence
- Co-Occurring Issues:
  - Addictions and Intimate Partner Violence
  - Mental Health and Intimate Partner Violence
- Elders and Intimate Partners Violence and Sexual Assault
- Documentation

### **i. Medical Model**

The Boston hospitals are fortunate to have innovative leaders, who understand the importance of addressing domestic violence and sexual assault as health care issues. The investment from senior management helps create support for the domestic violence programs within those institutions. However, on a daily basis, some health care providers will still ask why we are talking about domestic violence in this context. Some view it as a psychological or mental health issue, and some presume the solution to domestic violence to be straightforward and clear (e.g. simply requiring a call to the police or getting 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 health care domestic violence programs is to reframe this perspective. We need to educate providers about the complexity of the dynamics involved in abusive relationships and support providers in responding to domestic violence. Some providers will understand the complexity, but inevitably and understandably feel frustrated with the lack of quick resolution to the situation. A sense of fear and helplessness on behalf of a victim can compound the health care provider’s desire to “fix” the problem, and he/she may recommend, or sometimes, mandate a course of treatment or action. The patient who then may not follow this prescribed course is often labeled as “non-compliant.” The medical model and the provider-patient relationship has many inherent power imbalances that can replicate for some victims the feelings of being overpowered and controlled that are similar to the ways they are being treated by the abuser. This approach may further alienate victims/survivors from using health care services in general or the specialized services of domestic violence programs because they may perceive that others will tell them what to do, blame them for their situations, or make things even more dangerous or difficult for them.

## **ii. Family Centered Care**

The movement in medicine toward family-centered care has been valuable in mitigating some patients' anxiety while receiving medical care, and recognizes that the family may be an essential partner with the health care 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, for example 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 Boston programs have advocated for health care organizations and providers to build in time to meet each patient for at least a few minutes alone during each health care 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 domestic violence programs have scripted language for health care providers to empower them to state as a matter of policy or routine practice that they take a few minutes to meet alone with all of their patients. Situations where partners and family members refuse to comply with this request should raise red flags for providers.

## **iii. Health Care Settings as Public Places with Open Access**

Health care organizations' Public Safety and Security Departments are essential collaborators for internal domestic violence programs. Many Boston-area health care settings, including community hospitals and health centers are public places with open access, with thousands of visitors each day. Public Safety and Security have a pulse on safety precautions and are helpful in advising programs on the best way to provide access to services for victims of domestic violence if they are concerned about stalking, or being followed to their health care appointment. Even when privacy and confidentiality are preserved by the health care provider, victims in health care settings may be visible to abusive partners – literally because there are glass doors, and open public spaces. When an actual or potential threat to immediate safety is identified, clear protocols should be well-established with Public Safety/Security to address the threat. Additional concerns arise when both the victim 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.

## **iv. Non-Intimate Partner Abuse/Community Violence**

Policies and protocols on responding to cases of non-intimate partner abuse vary among health care domestic violence programs. Non-Intimate Partner Abuse (non-IPA) includes family violence, abuse by roommates, landlords, and health care providers, and both random and intentional community violence by non-related persons. With respect to non-IPA situations, it is



important to consider the program's capacity to provide direct services to victims of non-IPA, the context of the current safety concern, and other resources available to these clients. In some settings there may not be capacity to provide a direct service response to non-IPA situations. In these settings, health care DV advocates may be able to provide consultation to the providers working directly with these clients in order to share relevant expertise related to safety planning, risk assessment, legal options and community-based resources. In settings where there may be capacity to respond to non-IPA cases (perhaps especially in newer, developing programs) there may be benefits to providing a direct response to non-IPA, as it serves to cement the reputation of the DV program as a helpful consult service expert in matters of safety. Whether or not the DV program has capacity to respond to non-IPA, it is important to connect with providers and other experts who do serve this population of victims, for example many hospitals in the Boston area have child protection teams and/or advocacy programs for victims of gun/gang/community violence.

Upon assessment, many cases that initially present as non-IPA may be found to be occurring within a larger context of current or past intimate partner abuse, and therefore may better fit the parameters for client eligibility for services. For example, cases of abuse of an older woman by her adult child may also be occurring in the context of ongoing abuse by her husband.

Cases of non-IPA referred to health care 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 and family abuse issues. Important questions to be considered and addressed in program policy and protocols include:

- Will advocates provide direct services to non-IPA clients?
- If advocates will provide direct services, is there a limitation on length and scope of services?
- Will advocates provide consultation to other providers on these cases?
- Will the program be able to meet the needs of their target population if they increase the scope of services to respond to non-IPA cases?
- Will responding to non-IPA cases either compromise or enhance the mission of the program?

Given the complexity of cases, the lack of available resources, and the pertinent expertise possessed by health care DV advocates, it is likely that many programs will continue to provide some level of service to this population. It may be important, however, to articulate the limits of capacity to respond to these cases in policy and to connect with these resources as close partners in an effort to move towards more institutionalized responses for non-intimate partner abuse cases.

## **v. Mandatory Reporting**

In Massachusetts, there is no mandated reporting to the police or a state agency in cases of domestic violence or intimate partner violence, unless it is so severe that it falls under the mandate for health care providers to report gunshot wounds, stabbings with knives, and significant intentional burns on a person's body. In addition, any form of domestic violence may occur in a context that might warrant mandatory reporting of other forms of abuse, such as child



abuse, elder abuse, abuse of a disabled person or the required anonymous reporting of sexual assaults.

Some health care settings have specific consultation services to address mandated reporting of child abuse, elder abuse, or abuse of the disabled that arises in the provision of care. Given that many domestic violence victims/survivors will disclose information that may warrant mandated reporting, the health care DV programs may rely on the specialists in these consultation services to assist in considering the necessity of filing a report and in addressing the safety concerns that often surround reporting. The specialists are typically professional Social Workers, Physicians, Psychologists, and Attorneys, who may have varying levels of expertise in domestic violence.

DV programs in health care settings without a specialized consultation service will often face a few dilemmas. One is that they might have providers asking them for consultation around mandated reporting. Another dilemma is that the DV program may receive referrals from providers who either do not report when it is necessary, or decide to report when it is not necessary. For example, some providers file a child abuse report any time DV is mentioned, even if the child was not in the home at the time of the assault.

DV Advocates and other health care providers who subscribe to the empowerment model will tell a person experiencing domestic violence about mandated reporting requirements prior to conducting an interview. This gives the person an opportunity to make decisions about how much information to share knowing that the possibility of mandatory reporting exists. One example of how an advocate explains the concept to clients is:

*“Because I am a mandated reporter, if you tell me about any risks or harm to a child, elder, 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 because I know that it can make things unsafe and complicated for you. Let’s talk about what this means in some detail. Let me give you some examples, so that you understand what I mean by ‘risks’ or ‘harm.....’”*

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 victims of domestic violence are afraid of what the abusive partners will do once information is revealed that they have disclosed abuse. Make sure to find out the best way for the protective service agency (PSA) to contact the patient and communicate that strongly to the PSA. Safety plan with the patient about what to do once the partner finds out about the filing.

An example of a new resource meant to guide best practice around mandated reporting in child abuse is the [Promising Approaches Brochure](#), which was developed by a partnership of the Massachusetts Department of Children and Families (child protective services), DV Advocates and child protection consultants.

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

#### **vi. Employees Who Experience Domestic Violence**

All of the Boston programs provide a response to employees in the health care setting who experience domestic violence. The inclusion of employees emphasizes the programs' underlying assumption that domestic violence can happen to anyone and the recognition that safety, health and stable employment are interrelated. It also sends a message that anyone coping with domestic violence is entitled to the same level of care and services by a specialized program with trained advocates.

There are many important considerations to appropriately addressing domestic violence in the workplace, including the safety of the employee and workplace, privacy and the impact of domestic violence, if any, on work performance. In order to address the many nuances to this work, it is important to forge connections with employee assistance programs, human resources, occupational health, and health care security departments.

As one example, Partners Health Care'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 EAP employs a domestic violence specialist, and is a leader in the [Massachusetts Employers Against Domestic Violence](#) group.

#### **vii. Expert Witness Requests and Handling Subpoenas**

The Boston programs largely have kept themselves out of the role of expert witnesses in cases of domestic and sexual violence, with some exceptions, for two main reasons. The first, quite practical, is simply a matter of staff capacity. Programs do not want the role of expert witness to get in the way of providing acute and 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, in part, as the domestic violence movement continues to broaden its conceptions of power as being strictly a function of gender, requiring both health care and community-based programs to develop skill sets around determining who is the offender and who is the survivor. For example, as the movement grows in response to the needs of LGBTQ survivors, it has become increasingly clear that we can no longer assume who is the perpetrator and who is the survivor simply based on the genders of the individuals involved, requiring a more objective set of assessment skills that 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 on rare occasions for some of

the Boston programs to serve in the role of expert witness on behalf of clients; for example, providing evaluations regarding the impact of violence for lawyers going forward with immigration cases or in other circumstances as requested and deemed in the best interest of the client. This is a different role than serving as an impartial expert witness, but can entangle the domestic violence advocate into legal proceedings that should be entered into thoughtfully by program administrators.

In acute sexual assault cases, the Boston programs have largely deferred to the [Massachusetts Sexual Assault Nurse Examiner \(SANE\) Program](#) as experts. The SANE providers perform forensic evaluations and are trained to provide expert testimony for criminal court proceedings. However, as health care grows more conscious of the health impact of sexual assault, particularly the life long impact of childhood sexual abuse and the potentially enduring impact of chronic partner sexual assault, some programs are starting to provide services for non-acute sexual assault survivors 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 in these cases is largely beyond the scope of the health care based programs, some programs may, with significant thought, choose to provide such services where doing so would be in the best interests of the client.

The general protocol for handling subpoenas is to inform the survivor and seek guidance from the health care organization's legal counsel. All of the Boston programs have designated contacts within their organization's legal counsel's offices that 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 individual survivors in protecting their records against subpoenas.

It is important to note that health care organizations' legal counsel offices rarely have staff who specialize in the nuances of domestic and sexual violence law. Hence it may be the responsibility of the domestic violence program to empower the counsel's office with the information and expertise needed to better protect patients who are survivors. Community-based resources such as your local shelter or rape crisis center may be able to help to ensure that your organization and your program are fully aware of the legal protections in cases of domestic violence and/or sexual assault, which vary by state and also may vary by circumstances.

Recommended resources for more information are:

[Victim Rights Law Center](#)

[National Center on Domestic and Sexual Violence](#)

#### **viii. Co-Occurring Issues:**

##### **(a) 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 excuse subsequent violence. Some abusive people target individuals with substance abuse challenges, just as they often target other historically-oppressed and vulnerable individuals. A number of survivors use drugs and alcohol – not to

mention, food, shopping, and self injury – to cope in the face of the overwhelming stress of coercion, violence, entrapment.

The challenge for health care domestic violence programs is that addictions providers on the one hand, and domestic and sexual violence advocates on the other, have historically come from radically different frameworks. For grounded reasons, addictions counselors may believe nothing that 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, still the norm in addictions circles, 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 in general and women who have been subject to interpersonal violence in particular. A growing body of evidence indicates that survivors of domestic and sexual violence in general, and female survivors in particular, experience the best outcomes as a result of integrated trauma treatment that simultaneously addresses both the addictions challenge and the trauma, of which drug and alcohol use is so often just a symptom.

For domestic and sexual violence advocates who work in health care settings, the challenge of integrating these two frameworks is particularly acute, as they are often responsible for guiding practice in a way that is both trauma-informed and gender-appropriate.

#### **(b) Mental Health and Intimate Partner Violence**

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 batterers perpetrated abuse was because they themselves were mentally ill. We have come a long way from these limited explanations for partner violence, recognizing that mental health factors are but one part of a much broader set of personal, political, economic and other factors at the family, community, and societal/cultural levels that influence the choice to abuse a partner. Thanks in large part to the work of Judith Herman and others who have recognized the traumatic impact of abuse and the role that 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 have been labeled) as having mental health challenges, but that the cause of their violence is rarely due to their own mental pathology.

Similar to the historically different frameworks of the domestic violence and substance abuse fields discussed in the previous section, domestic violence and mental health experts have come from radically divergent perspectives as well. Whereas mental health providers have traditionally been trained to diagnose a pathology, provide treatments (including medication) and make referrals based on that diagnosis, domestic violence advocates have viewed what may appear as “symptoms of pathology” as expected and appropriate responses to real and

overwhelming situations of extreme and/or on-going abuse and control by a partner. At times, these responses may in fact be keeping the survivor safe; for example, hypervigilance is a natural reaction to repeated, unpredictable attacks and may help a victim by alerting her to situations that pose a threat. Advocates may also be concerned that medicating survivors could in fact 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.

A great deal of evidence points to the fact that the likelihood of developing many psychiatric conditions (including depression, anxiety disorders, substance abuse, PTSD, and suicidality among others) is correlated to severity, frequency and duration of abuse. Such evidence supports the need for strong collaboration between mental health and domestic violence experts, with the understanding that these conditions are more likely the result of the abuse than some inherent personality disorder of the victim, *and* that untreated trauma can be a real barrier to advocates' efforts to support survivors in regaining their lives. Survivors of abuse need access to appropriately trained, trauma-informed mental health clinicians and advocates, working together with the survivor to ensure all her needs are met in a way that does not inadvertently cause harm.

Recommended resource for more information: Domestic Violence and Mental Health Policy Initiative <http://dvmhpi.org/>

#### **ix. Intersections of Elder Abuse & IPV/SA**

We know intimate partner abuse occurs throughout the life cycle and affects elders in all types of intimate relationships. Domestic violence and sexual assault programs in health care 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.

Many of the Boston programs are involved in a collaborative called "SAGE (Stop Abuse Gain Empowerment) Boston," which has been working for over 10 years to bring providers and policy makers from the health care, elder/aging and domestic violence/sexual assault networks together to improve the response to older victims and survivors of intimate partner abuse. SAGE was founded by health care-based advocates who were seeing many older survivors of partner abuse, yet having trouble finding adequate and/or appropriate responses and resources in either the domestic violence network or the elder protective services network. Elder protective service workers and domestic/sexual violence advocates share a commitment to helping victims of abuse, yet have often operated from different frameworks and approaches, which influence how the cause of abuse is understood, where and from whom information is sought, who is offered what types of resources, what constitutes "success", etc.

One of the most important developments in our understanding of elder abuse that has significant implications for health care practice is the recognition that caregiver stress does not *cause* someone to be abusive, and so responses 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 in fact the caregivers for their abusive partners, and that the dependence of an older person on his or her partner for medical or other forms of 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 health care settings need to be prepared to encounter others who may 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, as well as survivors' experiences of fear, ambivalence, etc. are often very similar to those 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 age-ism, 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 that IPV in younger relationships does, 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 (whether on a consultant basis or through direct services depending on the specifics of the case, capacity of the program, and other factors) in ensuring that responses to older survivors are truly survivor-centered, trauma-informed, and considering all relevant dynamics, risk factors, options, and resources that may be involved.

More detail about work of the SAGE Boston Collaborative and other groups that are involved in similar efforts around the country to bridge these gaps can be found elsewhere (see link below). What is important to note is that 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 health care. The Boston programs and other members of this multi-disciplinary collaborative have come to recognize that, when developing health care based advocacy programs, a collaborative, team approach is essential.

Recommended resource for more information: [National Clearinghouse on Abuse in Later Life](#)

#### **x. Documentation**

The issues relating to documentation that the Boston programs in hospitals grapple with fall into two main categories: a) health care providers' documentation of abuse in the patient's medical record and b) domestic violence programs' documentation of their services, whether in the program's files or in the medical record. Each of these presents significant implications and challenges that need to be considered and reviewed periodically to ensure that the many (and sometimes competing) medical, legal, and safety needs of survivors are met.

The Family Violence Prevention Fund and others have developed some guidance for health care providers in how to document clinical findings related to abuse in the medical record appropriately, and while the specifics of "how to" are beyond the scope of this manual, the Boston programs have recently been involved in conversations about these issues, particularly in light of the recent nationwide shift toward electronic medical records (EMR). As one program



director stated, “What we (health care settings) are currently not doing well in paper records is magnified when it comes to electronic records.”

- a) Issues for domestic violence programs to consider regarding documentation by health care providers in the medical record.

A well-documented (accurate, complete, and objective) medical record ensures continuity and quality of care for any patient, especially in a setting where a patient may see many different providers over time. For survivors of domestic violence, the medical record can additionally serve as a valuable source of legally recognized evidence of abuse, whether the patient chooses to report the abuse now or in the future. As we enter the age of electronic medical records, however, even *appropriately* documented medical information recorded in the chart has potential to be viewed by those far beyond the intended audience, and/or used inappropriately by other health care providers, insurance companies, employers, or even an abusive partner or family member. The potential harm caused by *inappropriately* documented information is even greater, given the much wider scope of visibility and accessibility of the record. As with all sensitive information, it is important that providers use their own judgment regarding what and how information should be documented in a patient’s medical record, always mindful of why they are documenting what they do, and in accordance with the recommendations that have been developed by domestic violence experts/advocates. Anything documented should be relevant to the patient’s current state of health or well being and to the care being provided. Whenever possible, the patient should be informed as to how the information is being documented, and any concerns or fears the patient has relating to documentation should be taken very seriously. At a minimum, these steps will convey that the provider cares about the patient’s safety, respects her/his autonomy, and is mindful that the record belongs to the patient.

Additional factors relating to safety and confidentiality arise when the victim in the relationship is not the patient. Information about abuse in the record of a patient who is not the victim can increase danger to the victim, especially when the abuser has access to the record. Since the Boston programs also serve partners, parents, and other family members who are being abused by a patient, these considerations must be explicitly addressed with providers who may not be well trained in the dynamics and safety issues related to these complex situations. Depending on state laws and institutional policies, additional issues may arise when the victim is under 18, over 65, and/or a person with disabilities, as well as in cases involving sexual assault.

- b) Issues for domestic violence programs to consider regarding their own documentation of services

Historically, domestic violence programs in hospital settings have operated both philosophically and in practice in ways that more closely resemble community based domestic violence programs than hospital/medical practice. The recognition that “less is more” when it comes to documenting specifics about clients’ identity, needs, services provided, etc. has come from decades of experience that domestic violence advocates bring to the work. This can be very challenging and is often at odds with the medical mantra that “if it is not documented it did not happen”. The Boston programs have begun reviewing policies and practice relating both to their own record-keeping (in light of the increasing emphasis on evaluation in both the medical and



domestic violence fields) as well as methods for balancing the need for the health care staff to be able to see that a referral to domestic violence services was successfully made, without requiring too much detail about the nature of the referral, the specific services provided, etc. Each hospital's culture is different, and each program has had to find its own comfort level in balancing these complex and in many ways competing realities, which ultimately must continuously be informed by the experiences and needs of the survivors/patients we serve.

## 9. DOMESTIC VIOLENCE AND SEXUAL ASSAULT PROGRAM STAFF WITHIN HEALTH CARE SETTINGS

### a. The Role of the Advocate, with sample job descriptions

Program job descriptions provide information about the role of domestic violence advocates and staff in health care. 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;
- Boston Area Rape Crisis Center – Brief [Overviews of Management and Staff Roles](#);
- Massachusetts General Hospital – [Director](#) and [Advocate](#) positions;
- Passageway – [Director](#), [Program Manager](#) and [Advocate](#) positions.

Here is an example of the job posting for the Director position for the Center for Violence Prevention and Recovery at BIDMC:

*This full-time (40 hour/week) social worker will direct the Center for Violence Prevention and Recovery. S/he will lead the CVPR in its mission, focusing on strategic planning, fundraising, development, training, and the maintenance/development of community collaborations. This individual will be responsible for the administration of the CVPR, including overall program management, oversight of grants/contracts, and the fiscal oversight of the CVPR (with the Social Work Department Director and the Research Finance Department). This strong leader must continue the commitment of the CVPR and BIDMC to exemplary health care and responsiveness to victims of interpersonal violence. This individual will help to build the capacity of the program team and develop/maintain systems of oversight for all CVPR activities. His/her ability to both lead and nurture staff in their work and development is critical. Skills needed include experience in management of program and/or staff; demonstrated success in development and fundraising, strong written and verbal communication skills, as well as ability to lead in a healthcare environment. LICSW licensure with a minimum of 5 years management experience.*

When hiring domestic violence advocates and program staff, the Boston program leaders screen candidates for their ability to work within a health care setting. It is important to recruit program staff who are able to navigate the professional setting and the medical hierarchy with a sense of diplomacy and positive regard. Having empathy and appreciating the pressures on health care providers will help avoid burnout. Advocates who are used to being “on the outside” of large institutions need to make an identity shift. Advocates need to demonstrate a sense of collegial respect and become team members with health care professionals. Team work is essential in helping health care providers to more fully understand the dynamics involved in abusive relationship, as well as the importance of an empowerment perspective.

Some important factors to consider when screening candidates for DV/SA program advocate positions:

- Shared philosophy of empowerment and an advocacy model that focuses on self-determination;
- Reflect the patient population's cultural and racial identities;
- Knowledgeable about key domestic violence 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 health care 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.

One of the hospital domestic violence program directors noted, "Domestic violence advocates in health care need to be flexible and skilled. On a daily basis, they need to swim in different waters – sometimes as the tide is changing!" Another program director commented that sometimes advocates who work in criminal justice settings or in child protection settings may have a harder time initially working within health care where many victims of violence are not yet ready to take action or have had bad experiences with these systems.

Interacting with health care providers who engage in victim blaming or who want to "prescribe" a victim's course of action (such as, "just get a restraining order!") can be difficult for even the most well-trained advocate. Advocates need to have patience, empathy, and an ability to mentor and support health care providers to learn about domestic violence. They must be able to manage ambiguity, differing opinions and unsettling outcomes related to injury, poor health prognoses, and dangerous abusive situations. Finally, advocates need to be comfortable in guiding, teaching, modeling and mentoring others to respond more effectively to domestic violence.

## **b. Credentials and Training**

There is consensus among the Boston programs that advocates obtain, at a minimum, the 35-40 hour training that all community-based domestic violence programs in MA require of their staff and volunteers. Having a professional degree (such as a Bachelor's or Master's) can be helpful in building credibility as an advocate within a health care organization, especially in a community such as Boston where most hospitals (and all of the COBTH member hospitals) are teaching hospitals affiliated with area medical schools. The Boston programs highly value professional development for all staff members whether or not they hold an academic degree. Currently in Boston, the hospital program staff have the following degrees (listed in order of most common to less common):

- a. Masters in Social Work
- b. Masters in Public Health
- c. Bachelors of Arts
- d. Masters in Education/or Master of Arts
- e. Masters in Divinity

- f. Juris Doctor
- g. MD
- h. PhD in Counseling Psychology

Many advocates and program staff come to the health care setting with training that is consistent with the 40 hours of required training for advocates in Massachusetts community-based settings. There is not a uniform training program among the Boston programs. Newly hired staff and advocates receive orientation to their health care 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 health care rounds, Jane Doe Inc., community networking events, as well as local, regional and national conferences.

### **c. Clinical and Programmatic Supervision**

Advocates have varied backgrounds, including clinical training and as well as varied life experience. The health care domestic violence advocate role rarely requires 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 the provision of advocacy services in a health care context, programs and their clients are best served by integrating and prioritizing a structure for clinical and programmatic 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 practitioners will encounter challenging and difficult client interactions with some regularity. If left unattended and unexamined, these ways of interaction with clients 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 help to ensure both good standards of advocacy practice and retention of new and experienced staff.

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 in which to reflect on the importance of their role within the health care 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.

### **d. Relationships across disciplines within health care**

In order for any health care domestic violence program to be effective, the program staff must be able to cultivate authentic and productive working relationships across every discipline and

hospital department possible. It is a simple concept that takes thoughtful, deliberate attention in daily practice. Relationships take time to build, and sometimes require negotiating differences of expectations, opinions, language, philosophies and practices. Some relationships come easy and others may face obstacles, such as competing agendas, limited resources, and other factors unrelated to the domestic violence program's scope. Where there are differences, find common ground in which to connect, such as the hospital's mission to providing compassionate care to all patients or the hospital's commitment to high quality customer service. Being open to listening and engaged in learning are general practices that will serve program staff well in their efforts to serve survivors.

Sometimes the sense of urgency felt in a domestic violence programs is not shared by a particular provider or hospital department. One program director shared her difficulty in building relationships in one clinical area because the leadership kept changing and the health care providers seemed disengaged with the issue of domestic violence. She was frustrated because she knew that many victims/survivors would inevitably come in contact with this clinical area. She was eager to forge a working relationship with the providers so that they would view the program as a resource, and to perhaps offer the department training on domestic violence. She sought advice from a senior leader at the hospital who gave her the following advice: "Give it time – wait and see what happens. In the meantime, put your energy somewhere else where people are ready, willing and able to work with you." These are important lessons for programs to learn: Making an impact in health care requires patience, persistence and good timing.

#### **e. Support for Advocates and Program Staff**

The program leaders in Boston take care to attend to the needs of staff, especially 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 team work, 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 health care 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. It is essential to be clear about this, as most health care providers are expected to work within the walls of their institution, and thus may expect advocates/DV program staff to do the same. Attending community meetings and forums enhances advocates' abilities to provide effective services. It gives them a chance to connect their daily work within health care to a larger movement. Advocates learn new resources and engage with their peers across many different organizations and systems.

The program leaders in Boston 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 health care settings to get together and share their experiences and strategize about effective work in health care.

Many staff members of programs are also survivors of domestic violence and sexual assault, or know someone in their personal lives who has been affected. This issue is close to home for many of us. 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), which 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 alone. It provides education and training on secondary trauma, and seeks to mitigate its effects by offering psycho-educational support groups to advocates in a variety of settings, such as health care, 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.

## 10. Conclusion

### a. Future Programming in Health Care

The directors and program leaders of Boston domestic violence and sexual assault programs were asked to respond to the following question:

What would else would you do in your setting if you could? (e.g., you had the time and resources you needed.)

- “Create domestic violence programs within every health care organization within the state.”
- “Change my domestic violence program to become a dual DV and sexual assault program.”
- “Add a more robust prevention component to the program, with staff!”
- “Create an effective public awareness campaign about the health effects of domestic violence, and the availability of health care responses to domestic violence.”
- “Have a sexual assault/medical advocate located within every Emergency Department, all of the time.”
- “Develop a Safe Bed, or emergency shelter program that has the capacity to shelter individuals with complex medical conditions.”
- “Have clients/survivors become more involved in providing guidance and feedback to develop the program.”
- “Have advocacy services available 24 hours/day and/or a hotline for the program.”
- “Create a trauma-informed addictions team.”
- “Offer child care for support groups.”
- “Add a youth program manager to the staff.”
- “Hire a full time administrative support person.”
- “Hire a support group coordinator.”
- “Hire another full time advocate, or two!”



- “Hire an attorney for the program, or create a legal services partnership that provides access for clients to legal consultation and representation.”
- “Recruit Annie Lewis-O’Connor to work at my hospital, or someone just like her!”
- “Provide a foster care network for animals of clients who may become hospitalized and/or seek shelter where they cannot take their pets.”
- “Provide pet therapy for clients.”

## **b. Accomplishments in Boston**

To be sure, there is more to do. Domestic violence and sexual assault have not been eradicated, which is the ultimate goal. In the meantime, the health care system provides access to critical supports and safety options for victims.

We are still learning as we go, and are humbled and inspired every day by the strength, courage and resilience of victims and survivors.

Each of the leaders in Boston were asked to note something that they feel particularly pleased about as they reflect on their program's accomplishments within the last year. Here are some of their comments:

- “I feel proud of the relationships we have built with community partners over the years. We recently led an effective public service campaign. We were so pleased at how effective it was. As a result, we have new partners and leaders in this work.”
- “As a new program, the acceptance we have received has been tremendous. We have been particularly effective in working with funders to build support for health care, and recognizing the need for DV funding in the community.”
- “At our hospital, we have a strong investment from the leadership team. The Domestic Violence Advisory Council members have been great allies and supporters.”
- “Our legal services partnership has been great. We have sustained this work with consistent funding, and it has made a huge impact on clients.”
- “Being able to sustain the progress we have made and continue to build collaboration, despite the cuts in funding and the overall economy. We have maintained the footholds we have had in our program while moving forward.”
- “We’ve been able to have a presence within the health care system, with a lot of visibility for our program, and most importantly, visibility to meet the needs of victims and survivors.”
- “Our hospital has been screening ALL women for domestic violence in our Center for Women and Newborns, and has developed partnerships across disciplines and departments related to identification of victims of strangulation.”
- “We have instituted a column about domestic violence in every issue of the hospital’s weekly newsletter for employees and visitors.”
- “A Public Health Advisory on Domestic Violence in our state highlighted the need for heightened awareness and coordinated responses to prevent domestic violence homicides and victimization.”

## Appendix A – Brochures, Posters and Other Program Material

### Beth Israel Deaconess Medical Center

- [Advocacy Education and Support Project](#)
- [Community Violence Intervention Program Brochure](#)
- [Domestic Violence Intervention Program Brochure](#)
- [Center for Violence Prevention and Recovery Brochure](#)
- [Rape Crisis Intervention Program Brochure](#)
- [Center for Violence Prevention and Recovery Brochure \(Spanish\)](#)

### Boston Area Rape Crisis Center (BARCC)

- [BARCC Brochure](#)

### Boston Medical Center

- [Safety and Support Advocate Brochure](#)
- [Finding Safety Brochure](#)

### Brigham and Women's Hospital

- [Passageway Brochure](#)
- [Passageway Poster](#)
- [Passageway Resource Card](#)

### Massachusetts General Hospital

- [HAVEN Brochure \(Spanish\)](#)
- [HAVEN Bath Card](#)
- [HAVEN Brochure \(English\)](#)
- [HAVEN Poster 2010](#)
- [HAVEN Teen Brochure](#)

### Newton Wellesley Hospital

- [Domestic and Sexual Violence Services](#)

## Appendix B - Current and Past Domestic Violence Council Members 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](#)

[St. Elizabeth’s Medical Center – Domestic Violence Program](#)

[Child Witness to Violence Project – BMC](#)

[Children’s Advocacy Center of Suffolk County](#)

[Children’s Hospital Boston – AWAKE](#)

[Community Advocacy Program of CCHERS](#)

[Family Justice Center of Boston](#)

[Faulkner Hospital – Passageway](#)

[Journey to Safety – Jewish Family and Children’s Services](#)

[Lahey Clinic – 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 C - Massachusetts Resources

[Jane Doe, Massachusetts Statewide Coalition](#)

[Massachusetts Governor's Council on Domestic Violence](#)

[Massachusetts Public Health Advisory – June 5, 2008](#)

[PowerPoint Presentation for the Massachusetts Public Health Advisory](#)

[Massachusetts Medical Society \(see public health materials on domestic violence.\)  
www.massmed.org](#)

[Massachusetts Office of Victim Assistance](#)

[Sexual Assault Nurse Examiners Program](#)

[Neighborhood Health Plan](#)

[Employers Against Domestic Violence \(MA\)](#)

[CrossRoads at North Shore Medical Center, MA](#)

[Family Safety Project at Holy Family Hospital, MA](#)

[Victims of Violence Program – Cambridge Health Alliance](#)

[The Second Step](#)

[Massachusetts Department of Children and Families – Promising Approaches on Domestic Violence and Child Abuse](#)

## Appendix D – National Resources

[Family Violence Prevention Fund](#)

[Joint Commission Resources on Domestic Violence](#)

[Delphi Instrument/AHRQ](#)

[American Medical Association: Policies/Resources on Domestic Violence](#)

[National Sexual Assault Resource Center](#)