



Intersections

Domestic Violence and Allied Organizations Partnering for Health

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Introduction

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

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

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

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

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

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

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

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

Domestic Violence and Health

Modern History and Evolution

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

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

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

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

Domestic Violence Correlates to Top Health Issues

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

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

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

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

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

The Patient Protection and Affordable Care Act

The ACA in Brief

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

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

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

Helpful Definitions

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

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

The ACA and Women's Health

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

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

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

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

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

A Policy Perspective: Futures Without Violence

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

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

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

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

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

Domestic Violence and Primary Care

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

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

Community Health Centers

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

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

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

Project Connect

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

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

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

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

Reproductive Health and Home Visitation Programs

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

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

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

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

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

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

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

- *Time.* Health care providers may hesitate to engage because of concerns that adding assessment or interventions could take too much time, thus impacting their patient load. Likewise, domestic violence advocates may already feel overloaded and reluctant to take on “one more thing.” But in both cases, Duplessis says, “We can show them that it only takes a couple extra minutes.”
- *Referral resources.* It is important that when a health care provider has a patient who has disclosed domestic abuse, there are advocates ready to step in and take the handoff. Domestic violence advocates may themselves harbor concerns about referring clients to health care providers if there is any doubt in the provider’s sensitivity or skill in serving survivors of abuse. Forging and maintaining strong referral relationships, and making “warm” handoffs whenever possible, can help to assuage such concerns.
- *Confidentiality.* “This is always a sticky-wicket,” Duplessis says, “though sometimes it gets raised when there are other underlying issues because it’s the easiest barrier to throw up to slow things down. It’s critically important to work out confidentiality issues at the outset, and then move beyond them.
- *Funding and political support.* The political and funding climate has changed since 2010 when Project Connect was first launched. Domestic violence nonprofits are vulnerable to cuts in government funding, and public health programs are also struggling financially. Fortunately, willing partners can still be found among both groups.

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

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

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

What Does Collaboration Look Like?

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

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

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

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

Domestic Violence and Mental & Behavioral Health

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

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

The Impact of Abuse on Mental Health

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

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

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

The Domestic Violence and Mental Health Collaboration Project

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

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

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

The Trauma-Informed Approach

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

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

(continued)

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

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

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

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

- *Cross-disciplinary collaboration occurs within agencies.* Stronger integration between domestic violence and mental health services is not only a matter of collaboration across organizations, but *within* organizations. One partner agency had both domestic violence and mental health staff, but they were not working in concert. This initiative equipped the organization to better coordinate services, improve the quality of cross-departmental referrals, and work more effectively as a team.
- *Collaboration requires investment.* The success of initiatives like the Collaboration Project is due in no small part to the fact that that they are supported by paid staff. Having staff time set aside specifically to coordinate project activities is critical. Iser said: “People have to actually invest in collaboration. It doesn’t just magically happen.” It also requires an investment of time. Although it can take a while to get started (especially if engaging in thoughtful planning at the beginning), this ultimately saves time in the end.

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

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

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

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Cross-Disciplinary Partnerships: Key Competencies

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

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

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

- In January 2013, Shared Action, a capacity building assistance program of the Los Angeles AIDS Project, hosted a webinar on what HIV/AIDS services organizations should be prepared for under the ACA.^{ix} The main thrust of the webinar was that given sea changes specific to HIV/AIDS services policy and financing, in addition to ACA-related shifts, more organizations may want to use strategic restructuring to consolidate their strengths and better position themselves for the future.
- In September 2012, Grantmakers in Health released an issue brief making the case for closer integration of oral health care and primary care.^x The report, "Returning the Mouth to the Body: Integrating Oral Health and Primary Care," acknowledges that ACA ushers in new pay-for-performance payment mechanisms that could facilitate this integration, but it also notes that the roll-out of these new structures is still just getting underway.
- In August 2012, the SCAN Foundation, a funder dedicated to the health care needs of seniors, issued "Overview of Preparing Community-Based Organizations for Successful Health Care Partnerships." Written for long-term care organizations, the paper focuses on opportunities to provide care transition services to support hospitals in reducing readmissions.^{xi} The author identifies competencies needed for collaboration, including making a business case, excellence in service delivery, and evaluation capacity.

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

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

These competencies include:

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

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

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

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

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

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

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

Next Steps and Resources

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

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

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

Futures Without Violence

www.futureswithoutviolence.org/section/our_work/health

ACA Fact Sheet on Preventive Services for Women

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

National Center on Domestic Violence, Trauma & Mental Health

www.nationalcenterdvtraumamh.org/

Endnotes

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

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

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

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

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

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

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

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

^{ix} "Strategic Restructuring in the Affordable Care Act Era: The New Role of the HIV CBO," [Video] Shared Action, January 17, 2012 <http://youtu.be/-LQ7fvGmSU>

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

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