

Fall 2017

A New Way that Clinic Staff are Saving Lives in San Diego

Her abuser was sitting in the waiting room right down the hall at a Planned Parenthood clinic in San Diego when the patient told a medical assistant that she did not feel safe at home.

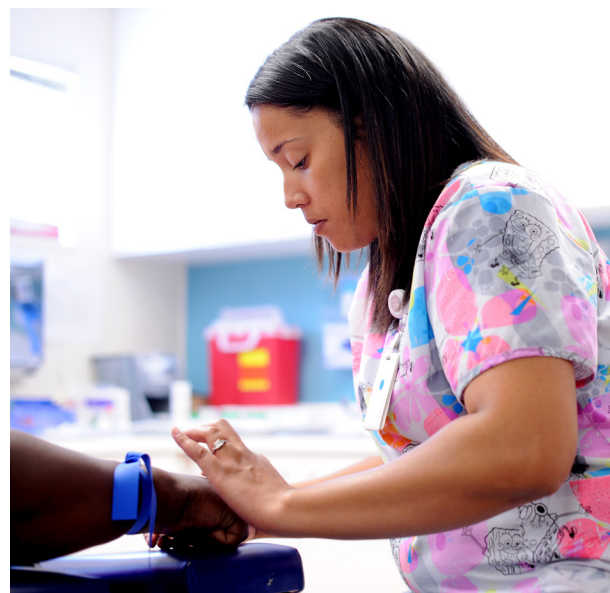
The revelation came during a routine screening process for domestic violence. Clinic staff snapped into action and called a survivor advocate from a nearby domestic violence agency who drove over to meet with the patient right away.

"If the survivor is isolated from friends and family, sometimes it's the only opportunity to talk to someone," said Cynthia Melchor, Community Outreach and Advocacy Coordinator at the Center for Community Solutions in El Cajon, CA. "Some victims are constantly guarded by their partner, who is monitoring their phone, who they call, and where they go. This was a key opportunity for me to talk to her one on one."

Since patients feel a sense of trust, privacy, and safety at medical appointments, the women's health clinic setting provides a unique opportunity to discuss and address domestic violence, Melchor said. The center began partnering with local women's health clinics run by Planned Parenthood of the Pacific Southwest and Family Health Centers of San Diego in order to teach staff how to screen for domestic violence, educate patients about safe and healthy relationships, and respond to the needs of survivors who look to them for help.

The collaboration comes at a time when there is increasing awareness about how trauma affects all aspects of an individual's health. Patients experiencing domestic violence may seek treatment for headaches, depression, anxiety, or other signs of stress when abuse is the true root cause.

"If we can develop a screening process for our women's clinic, maybe we can keep them out of the emergency room," said John Bridges, Medical Clinic Director at Family Health Centers of San Diego, which has eight women's clinics in its federally qualified health centers serving uninsured, low income and medically underserved patients.



Melchor was able to help the patient in crisis, who said she was experiencing verbal, financial, and emotional abuse. She talked to her about what she wanted to do, arranged somewhere safe for her to go and connected her with legal assistance to file a restraining order against her partner.

"The partner didn't even know I was there," Melchor said. "He was escorted out by law enforcement."

Of course, each case is different, with the majority of women not needing or wanting that kind of immediate crisis intervention, Melchor said. Many women may want counseling or information about other services and support groups. Some patients who are referred by the clinics to Melchor want to meet her at a public place to chat, or prefer to talk by phone.

Patients who disclose abuse at the clinics are in a different frame of mind than those who go to a domestic violence agency directly for help, said Chrissy Cmorik, Education Outreach Manager for Planned Parenthood of the Pacific Southwest.

It often takes multiple screenings before a patient is ready, if ever, to disclose problems with their relationship, Cmorik said.

Patients feel a sense of trust, privacy, and safety at medical appointments

"This is someone who came in for a PAP smear and ends up talking about some concerns at home," Cmorik said. "Someone going to the center directly is ready to take action and make that change. Our patients aren't necessarily ready to make that change."

Many patients are not ready to even describe their situation as "domestic violence." Melchor had to change how she identified herself when she phoned patients referred to her by the clinics. She initially introduced herself as a "domestic violence advocate," Cmorik said.

"Patients would hear she is the 'domestic violence advocate' and they would say they didn't need or want that," Cmorik said. "So we started calling her a 'health advocate' who could talk to patients about what's going on in their relationship, offer counseling or couples therapy or in a broader sense, safety planning and that was better. It was really interesting."

It often takes domestic violence survivors a while before wanting to change their situation even after they have disclosed abuse, Cmorik said. Melchor may reach out to a patient at their request three or four times before they end up calling her back, Cmorik said.

Since patients may sometimes be accompanied by their abuser, child, friend or relative to medical appointments, the clinics created a policy to always screen for domestic violence when patients are alone – not allowing others to be present when questions are being asked.

Patients are brought back to treatment rooms, where medical assistants will inquire about relationship violence while gathering the usual information about medications, height, weight, and blood pressure.

"You aren't going to get an honest answer if a boyfriend or sister is there," Bridges said. "We realized we needed privacy to get an honest answer. That worked."

When staff receives pushback from partners about bringing a patient back on their own, they cite medical privacy laws to explain it. They also offer that the partner or friend may be able to rejoin the patient at some point later during the appointment, which usually defuses the situation, Bridges said.

The center hired a temporary women's health coach to help them come up with a protocol for screening for domestic violence. Now, all staff can follow the system that's in place even if there is turnover, Bridges said.

At the center, patients are given a laminated piece of paper with questions to answer about whether they are experiencing abuse along with an erasable marker. The medical assistants record the information in the patient's electronic health record and if the patient disclosed domestic violence, the medical assistant will alert the provider.

"A first, it was awkward," said Selene Cuapio-Diaz, Lead Medical Assistant for the FHC. "I wasn't used to asking personal questions. If someone says, 'Why are you asking me?' I explain that we are working to create awareness."

Now, having the right resources to offer the patient feels empowering, Cuapio-Diaz said.

"They know what's best for them," Cuapio-Diaz said. "We are not here to tell them what to do with their relationship. We just give them the resources, legal assistance, support groups. We have information to give them."

Patients are screened once a year. In the last 29 months at the, there have been 28,000 patients, 16,000 of whom were screened, with 185 positive disclosures, or about 1.2 percent, Bridges said.

"It's not a program we run, it's part of what we do," Bridges said. "Just like taking blood pressure, weight and height, it's a part of what we do. It's ingrained in our culture at the clinic and that's how it can be a lasting legacy."

Providing a private environment for patients required the center to rearrange offices so patients wouldn't be screened for domestic violence in one area and then have to walk back through the lobby, where their abuser may be waiting, Bridges said.

The Planned Parenthood clinics also screen patients alone for domestic violence and changed other policies to further protect privacy. After a surgical procedure, such as an abortion, patients were required to have a ride home arranged with a trusted family member or friend, but sometimes the only person a woman can turn to for a ride is the abuser, Cmorik said. So, now patients can use a rideshare service, she said.



The physical environment in a clinic, how the space looks, can also help make patients feel safe and more likely to disclose trauma, Cmorik said.

"Our health centers are nonprofit and the carpets were messy, some chairs were ripped up, there was some graffiti and they were not looking the cleanest," Cmorik said. "There was a thick glass partition between the receptionist and patients. We did a 'refreshing' to all of our health centers. We want them to be calming and soothing. We set up more couches and chairs. We now have charging stations for phones and removed glass partitions when we can. They are really beautiful centers. It's a safer feeling and everyone is more at ease."

“We want to make this a normal part of talking about your health”

Busy clinicians and staff can feel overwhelmed by the idea of taking on a sensitive and daunting issue like domestic violence.

The center did trainings for Planned Parenthood's 13 clinics about how to normalize conversations about domestic violence and how to respond and refer patients for services. Planned Parenthood screens women once a year or if they have a new partner. Because staff is so busy, the typically longer trainings offered by the center were changed to shorter more frequent ones, Cmorik said.

Melchor would stop over periodically to all of the Planned Parenthood and FHC clinics to make sure information pamphlets on domestic violence and resources are restocked for patients and answer any questions from staff on how to make referrals for patients who need help.

“We want to make this a normal part of talking about your health,” Cmorik said. “We want to make sure we do it in a trauma informed sensitive manner, like not have our backs to the patient typing away as they tell us their story.”

To ease concerns about how to bring up the topic, there are cards attached to staff computers, which prompt the medical assistants on what they can say, including, “Are you feeling safe at home? How is your relationship at home? There are people we can call to give you more information. Thank you for trusting me with the information,” Cmorik said.

If patients disclose that they are experiencing domestic violence, the clinics will refer them directly to Melchor, who can connect them to needed services.

“It's very hard when you have a patient disclosing something very personal, Cmorik said. “We don't want to just give them a referral. People have given me referrals and I've never done them. For someone going through trauma, we want them to talk to somebody. We want to be warmly handing off the patient to someone who we trust.”

Last year, Planned Parenthood of the Pacific Southwest referred 74 patients to the center, up from 33 patients in 2015.

“We know violence isn't just happening more, but now we are able to be a safe space for patients to talk about it,” Cmorik said.

In return, Planned Parenthood staff has consulted with the center to help them address the reproductive health needs of domestic violence survivors.

For women who have fled their homes to come to shelters, the clinics can offer testing or treatment for sexually transmitted diseases, as well as pregnancy testing, access to the morning after pill, or birth control supplies, Cmorik said.

“Violence plays a huge part in health,” Cmorik said. This is treating the whole patient. This has allowed us to see how we can provide support. You can't treat the patient and not consider what they are going home to.” ■

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It Takes a Tribe: Building Trust and Partnership to Address Domestic Violence in Sacramento's Native American Community

It's already difficult enough for women to seek help when they're experiencing domestic violence, but for California's Native Americans, there are even more barriers.

In addition to the burden of historical trauma, cultural traditions and social norms uniquely influence the way that violence is handled and experienced by Native Americans. Living within small tight-knit communities, survivors often fear that reporting abuse will stigmatize or even destroy their families. There is also significant mistrust of government authorities to act fairly and effectively if they were to reach out for help.

"When there has been too much negative interaction with law enforcement, they just don't want another male persecuted by police," said Beth Hassett, executive director of Women Escaping a Violent Environment (WEAVE), a Sacramento County group that offers crisis intervention services for domestic abuse and sexual assault survivors. "They think it's better to suck it up and live with it than to further traumatize the community."

WEAVE has been working to build trust in the tribal community by partnering with the Sacramento Native American Health Center (NAHC).

"We need to keep an open mind to language we use that may not feel welcoming. We need to be open about how we can help people in all cultures," said Hassett.

The idea for the partnership was to integrate domestic violence intervention and prevention into the healthcare setting, where providers are respected figures, in order to reinforce that a healthy relationship is part of a healthy life.

Staff members from the two organizations met regularly to discuss their roles in helping survivors. Thankfully, their offices are only a block apart in downtown Sacramento.

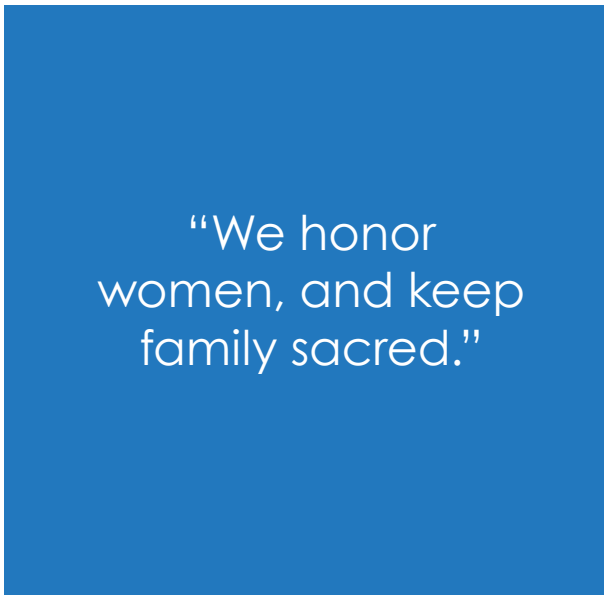
Through its partnership with WEAVE, the Native American Health Center also set-out to improve its ability to respond to their patients who are experiencing abuse. Rates of domestic violence among Native Americans are higher than most other racial and ethnic groups, which results in more patients presenting signs of domestic violence and dealing with its resultant impacts on health.



The clinic, which is a federally qualified health center, says that one in four of its patients is a Native American member of a local or out-of-state Tribe.

"We needed to be seen side by side in the community," Hassett said. "We want to be seen as partners in their health. Health providers and WEAVE staff spent a lot of time going to events in the community."

WEAVE staff would appear with clinic staff at community events, pow-wows, and health fairs and created co-branded educational materials on healthy relationships.



"We honor
women, and keep
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"Not everybody is ever going to leave their relationship. Families are so intertwined in Native American communities. We are not going to make you leave your relationship. We just want you to be safe in it and to heal your whole family."

WEAVE hired Native American staff members to work with Native American clients and bring creative arts practices into the support groups for survivors. The groups use art intervention, drum-making, bead work, and other culturally responsive methodologies for healing and coping.

WEAVE also trained health center staff on screening for domestic violence and how to respond to patients with empathy and navigate necessary referrals to outside services.

Now, thanks to the partnership, from the moment a patient sits down in the health center waiting room, educational messaging from WEAVE reaches them. Television monitors show a video that plays on a loop in which a Native American woman in scrubs is shown saying, "violence is not a part of our tradition. If you are experiencing violence, this is a safe place to talk about it."

"It's priming people to feel safe and that we are culturally specific, talking about tradition and family in ways that we've found resonate with the patients," Hassett said.

Because patients may have multiple appointments with different providers, the screening is done only once each time they are here, said Nicole Bozzo, behavioral health department manager at the NAHC.

While screening is a critically important part of intervention and prevention of domestic violence, it is not the only pieces of the puzzle. "We constantly implement the message that 'violence is not traditional,'" Bozzo said. "How we communicate, who's on our staff, and how we show up authentically and genuinely plays a big part. We continue to reinforce the mantra that 'We honor women, and keep family sacred.' And we remind the community that resilience is who we are. We are resilient when we support each other, and stay connected to our culture, ancestors, and tribe."

A domestic violence advocate from WEAVE works onsite at the health center and can be called-in whenever needed to help patients who are in crisis or need immediate support. For safety and privacy, the advocate walks through the back of the offices to reach patients so that they are not seen talking to her by anyone in the waiting room. Patients can also be escorted to WEAVE's office nearby, or consult with an advocate by phone if they prefer.

"Having a really warm hand off from the clinic makes the biggest difference," Hassett said.

To reduce the social and cultural stigma that sometimes prevents survivors from participating in group therapy, which meets twice a month, WEAVE started referring to it as a "healthy relationship healing group."

In addition to a growing numbers of patients willing to participate in these groups, in the last year, the clinic screened 1268 Native American patients during routine visits, and 107 indicated that they were interested in seeking services from WEAVE, Bozzo said.

"We thought that was a big number," Hassett said. "In our minds, it's a huge thing that people are feeling comfortable enough to disclose domestic violence in such a small community."

The clinic also wants to help prevent violence among younger generations and help abusers get the support and services they need to stop violent behavior.

"We want to address the prevalence of violence and the root causes for it," Bozzo said. "Abusers don't just start abusing. They experienced trauma themselves. We don't want to shame abusers or ignore their need for services."

There are programs for men and families that don't initially appear to relate to domestic violence, but they all have a theme of "we take care of our families," Hassett said.

A 2014 report by the U.S. Centers for Disease Control and Prevention found that an estimated 51.7 percent of American Indian/Alaska Native women experienced physical violence by an intimate partner during their lifetimes, a rate that exceeds that of any other racial or ethnic group.

"The prevalence of violence going on in our community is heartbreaking and shocking," Bozzo said. "We want to be a safe space to

help survivors gain access to whole-person care, not just serve the physical but the mind, body, and spirit."

There is a joke, made with dark humor, on reservations that highlights the pervasiveness of violence against women, said Jesus Sanchez, a WEAVE counselor who runs group therapy sessions for the clinic. "How do you know if a native woman is married? She has no teeth."



Domestic violence can become so normalized that some women don't even realize they are experiencing it.

"Some women will share their story and ask, 'Is this even domestic violence?'" Sanchez said. "They'll say he messed up my house, he's stalking me, he burned my house, but he didn't hit me."

Verbal abuse can be just as damaging when survivors internalize the criticisms of their abusers, he said.

Sanchez once asked those attending a 20-member group therapy session to write down a message from their abusers that they have internalized that gives them a negative perception of themselves, such as "you are a bad mom."

“We want to be a safe space to help survivors gain access to whole-person care”

The group members had the option to read aloud the internalized belief or share the effects the message had on them, then rip-up the piece of paper and throw it into a trash can symbolizing a fire, Sanchez said. Next, each group member wrote a positive message to someone else in the group to replace the negative one. Even if they didn't know the other person, they could say, “You are strong and resilient to share your story,” Sanchez said.

“Part of the medicine is to put the message into the ‘fire,’ to help with healing,” Sanchez said. “Medicine is anything that reminds you of your path to healing and that soothes you and grounds you. Carrying negative ideas about themselves keeps people back. It was a powerful session.”

After gaining confidence from group sessions, some participants have approached Sanchez for individual therapy. They often express anxiety about privacy.

“Some of our clients are relieved I’m not a California Indian,” Sanchez said. “My tribe is from Texas. Some Native Americans from rural areas can’t access services because a cousin of the perpetrator works at that office so there is not a sense of confidentiality.”

Clients sometimes ask him to meet with them at the WEAVE office because of a concern like “their ex-boyfriend’s aunt is a secretary at the clinic and will see me with you,” Sanchez said.

“At a different place, I saw a victim being screened, and her abuser was the one who was translating for them. That’s not how it’s supposed to work. Seeing patients alone gives them the opportunity to get out of danger.”

The privacy given during screenings is critical.

“We’ve literally had an abuser in the lobby when a patient shared with us that she was in serious danger. We helped get the survivor out of the state. She was in such an adverse environment. She knew if she was with him any longer she would wind up dead.”

Integrating domestic violence into the health-care setting isn’t just a novel approach, it’s “absolutely lifesaving,” Sanchez said. ■

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On-site & On-Call: Domestic Violence Advocates Bring Direct Services & Support to East Los Angeles Hospital

A woman in her 60s with high blood pressure looking for help for her chronic pain kept visiting her primary care clinic in Los Angeles, but doctors were baffled. No one could suggest a clear-cut explanation for the patient's symptoms.

Her doctor, Janina Morrison, suspected something else was contributing to her symptoms. "I got the sense that she was depressed, but she refused mental health help," said Morrison, a primary care doctor at Los Angeles County + University of Southern California Medical Center (LAC+USC). "She wasn't doing well, and she was very stressed out. She was doing things like calling the police about her neighbors a lot and it was causing problems with her landlord and she was at risk of homelessness."

So, Morrison sent her to the Wellness Center on USC's campus, which houses a number

of community-based organizations that offer culturally sensitive health programs, classes, and counseling. The patient met with a "wellness navigator" who told her about available services in her area, including those provided by East Los Angeles Women's Center (ELAWC), a domestic violence resource and advocacy organization.

That was the turning point.

"She disclosed that in the past she was traumatized by domestic violence and something about her neighbors was triggering that for her," said Morrison, "It was a real revelation for me. It very clearly explained everything."

Since opening a second office onsite at the hospital four years ago, ELAWC has been transforming how domestic violence is handled by healthcare professionals at one of the largest public hospitals in the country.

When summoned by clinicians and staff anywhere on the LAC+USC campus, ELAWC advocates show up within 15 minutes. It used to take up to an hour to get to the hospital from their primary location in the city.

Now, advocates are able to immediately help patients in the emergency room, the 600-bed hospital, or in outpatient offices. They also train medical students, clinicians, and staff on how to screen for and respond to domestic violence.



Clinicians can also refer their patients directly to ELAWC's onsite office, located at the historic former general hospital building, where they can receive bilingual crisis intervention; counseling, individual and group therapy, HIV testing, and referrals to housing, child services, and legal aid.

Morrison's patient with chronic pain didn't disclose her history of trauma when she had been asked about it before at clinic appointments.

"I'm not the most culturally competent," Morrison said. "At the community organizations, people are bilingual, they have more time. It's sometimes a better place for someone to disclose their domestic violence."

With their constant presence on campus and educational programs and training, clinicians have come to recognize the ELAWC advocates as specialists who are a vital part of the healthcare team, said Rebeca Melendez, LAC+USC Wellness Center director.

"We are trained to diagnose domestic violence situations," Melendez said. "We are specialists in care. The administration stands behind our work. That has been the key to success. They vouch for us."

Doctors, clinicians, and staff who never felt like they had the experience or expertise to tackle a sensitive issue like domestic violence now feel empowered, Morrison said.

"We are a safety net hospital with patients who have a lot of social struggles and physicians who may not be able to help them," Morrison said. "But because of this relationship we have with East Los Angeles Women's Center, we have been able to do more and feel more comfortable that we are helping them."

There is increasing recognition in the healthcare field that social determinants of health are huge obstacles for patients, Morrison said.

"Having wellness advocates onsite is an experiment in how to quickly address these complex needs so we can get better care for our patients," Morrison said.

The survivors
feel like they
are making a
difference by
sharing their
experiences

At their office on the medical campus, ELAWC sees up to 32 clients a week for counseling, consultation, and connections to other forms of needed support, said Morrison.

"I take care of patients with chronic disease, people struggling with diabetes," Morrison said. "I have been shocked by how the main obstacle [to better health] turns out to be their domestic violence experience and how common domestic violence is. It is so prevalent and so tied up with self-care. People do not have the wherewithal to manage chronic health conditions because there is so much unresolved trauma."

ELAWC has been a resource for domestic violence survivors in the East Los Angeles community since 1976, when it became the first bilingual English-Spanish hotline for victims of sexual assault in Southern California.

"We'd respond to the emergency room and had established a relationship with physicians there," said Barbara Kappos, executive director of East Los Angeles Women's Center. "That's how we got to know their system. They didn't have screening tools or a large-scale response plan to domestic violence. We wanted to begin to educate, mobilize and build awareness around these issues in all parts of the massive medical system."

To start the partnership, ELAWC worked with leaders at LAC+USC to form an interdepartmental task force to identify ways to better address domestic violence in the healthcare setting. Today, the partnership has expanded to include broader and deeper approaches to prevent and address abuse.

At a recent event at LAC+USC medical campus, suitcases with items packed by actual survivors before fleeing their violent situations were set up in the hospital's courtyard. Advocates stood next to each suitcase, talking about the survivor's story and taking questions.

"Just being able to hold that event would have been impossible without this partnership," Kappos said. "The amount of red tape involved just to get approval and get it set up would have been impossible if we were not already a trusted part of the system."

The educational work led by ELAWC isn't only for healthcare providers. The group has also trained clergy members who visit patients at the hospital on how to identify domestic violence and what resources are available to help them, Kappos said, since some patients will feel most comfortable confiding in them. Working with medical students at the Keck School of Medicine, ELAWC is preparing them to enter the medical field with an understanding of how to more meaningfully and effectively help patients experiencing domestic violence, Melendez said.



ELAWC leads basic domestic violence and sexual assault response training for all medical students. This includes how to convey an open and nonjudgmental tone to make a patient feel safe, Melendez said. Trainers often bring survivors who give personal testimony about their medical care.

At one training in April, a medical student asked a young survivor what she could say, as a provider, to make a patient feel more comfortable in disclosing trauma.

"It's not about what you can say," the girl told the medical student, Melendez said. "Look at you. I am looking at you and all I can think is I'm this little brown girl from the hood. You are beautiful and educated. I'm just here praying that you don't judge me."

The survivors feel like they are making a difference by sharing their experiences, Melendez said.

"There wasn't a dry eye in the room," Melendez said. "It's beyond powerful."

But what happens when there is a patient in crisis, who has told her provider that she's experiencing domestic violence, but is about to be released from the hospital - often back into an abusive environment? The partnership between ELAWC and LAC+USC now has an answer for that. The partners are planning what will be the first-ever in-hospital shelter in the country for domestic violence survivors. It's currently set to open in 2018, Melendez said.

ELAWC identified this critical gap between when a survivor is released from the hospital to when they can get into a shelter or housing plan. Sometimes that gap puts survivors in dangerous and compromising situations or in shelters that aren't appropriate, she said. Advocates used to sit with patients around the clock in the waiting room trying to arrange for housing. But, if there is nowhere to go, the survivor is at risk of returning to the abusive situation from which they are trying to flee.

The 24 hours after a survivor is released is a critical time to work with them, Melendez said.

The hospital received funding from the county to have 10 beds for survivors who are actively leaving violent situations. During their stay at the in-hospital shelter, the patients will receive intensive case management from ELAWC to develop a safety plan and help them find a more long-term housing solution, Melendez said.

"This is an amazing opportunity and a game changer for how medical services are provided to domestic violence survivors," Melendez said.

Prevention and education about domestic violence in the community is another important focus of ELAWC.

To help break the cycle of violence and address the multiple factors that influence its perpetuation, they provide community prevention workshops; support groups for survivors with HIV; youth empowerment programs to prevent teen dating violence; workshops for parents, abusive partners, and young women and girls; as well as trainings for "Promotoras" - who are often survivors themselves - to become certified community advocates and help build awareness about violence against women and available resources.

"Sometimes when I'm leaving for the day, I'll see a class of teenage girls doing empowerment activities," Morrison said. "East Los Angeles Women's Center is helping the next generation really early on. The prevention work that they're doing is going to be harder to measure the impact of but it may be the most high yield thing that they do."

Officials hope the partnership between ELAWC and LAC+USC can be a model for how domestic violence is addressed within the healthcare system, Morrison said, even if the circumstances are different.

"Not every hospital is going to have 40,000 square feet to remodel and bring in community based organizations on site," Morrison said.

Other hospitals or health systems without sufficient space or funding for this type of endeavor could still have "virtual collaboratives" that can offer navigation services to outside resources, she said.

"Of course the question is how do you pay for this?" Morrison said. "East Los Angeles Women's Center gets grants and the Wellness Center gets grants. We do think this should be an embedded part of healthcare system. It benefits patients who are very expensive to the healthcare system. These patients have stopped going to the Emergency room. Spending money on the Wellness center is better than spending on more expensive care."

"This is an amazing opportunity and a game changer for how medical services are provided to domestic violence survivors"

Since addressing her past domestic violence experience as part of her care, Morrison's patient with chronic pain has thrived. She has started exercising, eating healthier, got an emotional support dog, and does more self care, Morrison said.

"I have a totally different sense of what is influencing health in a way I never had when I was working in a clinic without these vital services," Morrison said. ■

Fall 2017

In Santa Clara, Helping Healthcare Providers Ask the Right Questions about Domestic Violence

The staff at the MayView Community Health Center never used to try and figure out whether their patients were victims of domestic violence.

Busy doctors, nurses, and medical staff lacked the time, expertise and resources to confidently approach the issue of domestic violence, so they simply didn't address it until a patient asked for help or showed clear physical signs of abuse, said Griselda Lopez, Director of Clinic Operations for MayView's three nonprofit clinics in northern Santa Clara County, CA.

But when they decided to start asking all of their patients about domestic violence, everything changed.

"Many of our regular patients, who we saw constantly and never knew they were experiencing those difficulties, came forward," Lopez said. "It was surprising."

MayView began partnering with Next Door Solutions to Domestic Violence in San Jose, CA, where they had referred a handful of patients in the past. They began to deepen their relationship and work together to integrate domestic violence prevention and intervention into primary care in much more intentional and enduring way.

Next Door Solutions offered training for doctors, nurses, and medical staff on how to screen for domestic violence, educate patients, and connect them to the right services.



"Do you really want to surface it if you don't have anything to do for the patients?" said Carolyn Purcell, behavioral health program manager for MayView. "You have to be careful that you are really ready or you could be doing more harm than good."

Domestic violence is increasingly recognized as a public health issue, along with other forms of trauma, given its significant impact on patients' overall health and well-being.

"We know that health care is a natural place to discuss the issue of domestic violence," Colsaria Henderson, director of programs at Next Door Solutions to Domestic Violence, which offers a crisis hotline, emergency shelter, crisis counseling, legal advocacy, bilingual support groups and case management.

"The patients know there is privacy protection and feel like it's a safe place. Even if they don't go to the doctor for themselves, women who are being abused will still take their children to the doctor."

Because patients often visit primary care offices routinely, rather than only in an emergency, these doctors can help identify the individuals who need help for domestic violence before the abuse escalates into a life-threatening situation.

"People go to the doctor because they are having headaches, anxiety depression or other trauma signs and symptoms," she said. "It's a logical place to start."

The Centers for Disease Control called intimate partner violence a "major public health problem" in the United States in its 2010 National Intimate Partner and Sexual Violence Survey. Many survivors can experience physical injury, mental health consequences such as depression, anxiety, low self-esteem, and suicide attempts, and other health consequences including gastrointestinal disorders, substance abuse, sexually transmitted diseases, and gynecological or pregnancy complications, the report said.

A 2013 study from the MORE Magazine/Verizon Foundation found that a majority of women, 81 percent, who experienced abuse also had a chronic illness or health condition and had regular contact with a healthcare provider. But only 24 percent of the women said their healthcare provider had ever asked about abuse.

To develop a plan for responding to domestic violence in a healthcare setting, leaders from Next Door Solutions and MayView held meetings to establish shared goals and discuss the partnership in 2015. Then, a project coordinator from Next Door Solutions visited each clinic to observe the work-flow and culture.

Next Door Solutions then developed tailored trainings for MayView staff, which included how to talk about such a sensitive issue with patients, the legalities around mandatory reporting of abuse, and how to incorporate domestic violence education into each appointment as a form of preventive care.

The trainings, attended by all MayView staff members, addressed the definition of domestic violence, the dynamics of power and

control in abusive relationships, and what barriers victims face when they consider leaving. A survivor even gave a firsthand account to staff about her experience and what she needed for help.

The staff members learned how to manage family members and significant others so that the patient could be screened privately, how to include cultural considerations when working with victims, and how to respond to disclosures of abuse in a supportive way.

Several staff members even volunteered to do 40 additional hours of training to become advocates in their own clinics.



"This is about
trusting the
partnership."

"There was fear on the staff about what happens when someone says yes, what if the perpetrator is in the lobby, so it was good to talk about those fears," Henderson said. "This is about trusting the partnership. Staff needed to know if they refer a patient, that person would get help."

Leaders at MayView and Next Door Solutions decided to implement mandatory domestic violence screenings for all women and adolescent girls - along with men and boys presenting symptoms of abuse - before every primary care visit, family planning visit, and pediatric and prenatal visits.

When patients check-in for their appointments, they are given a printed questionnaire asking, in both English and Spanish, if they are experiencing or have ever experienced domestic violence.

"It's just a piece of paper," Lopez said. "But it works really well."

After patients are brought back privately to the treatment room, the medical assistant goes over the questions with them and enters the answers into their electronic medical record. This process gives patients a second opportunity to disclose abuse in-person. As the medical assistant enters the answers into the health record, the system prompts them with what to say or ask next.

If the patient indicates that they are experiencing or have ever experienced domestic violence, the medical assistant will inform the primary provider, who then attempts to find out the full history of abuse and look for injuries or scars.



An on-site advocate then helps determine if it is safe for the patient to go home, what the risk is for any children in the home, what other resources are needed for the patient – such as housing or transportation – and if there is any risk of suicide. The patient could then be directly connected to counseling and support groups on-site at the clinic while a safety plan and other services are being put into place.

As an educational tool, all patients – regardless of how they answer the screening questions – are given a wallet-sized information card discussing the characteristics of a healthy relationship along with signs of abuse, as well as phone numbers and websites for more information and resources.

"We do give the card to everyone regardless of disclosures," said Samantha McCarthy, Human Resources Coordinator for MayView Community Health Center. "It is all about education and awareness."

The cards are posted throughout the clinic – in the exam rooms, restrooms, and waiting areas – so that patients can take them from wherever they like, or bring them home to friends or family members who may be experiencing domestic violence.

Since it may take a while, if ever, before patients in abusive situations to feel ready to seek help, the clinic sees its main goal as educating the patient community about the signs of domestic violence and the resources available, McCarthy said.

Asking about domestic violence and giving educational materials at each visit provides a constant reminder to patients that the clinic is a safe place to turn if they decide to divulge their abuse, she said.

Some staff initially had doubts that it would work to screen patients at every visit, Lopez said.

"Once we established the work flow of the questionnaires and once they noticed they could help patients, at the end it was positive," Lopez said.

The clinics have screened 6500 patients since they started in November of 2015. Six percent of the patients said that they were currently experiencing domestic violence and more than half of the patients said they had experienced it at some point in their lives.

Survivors of abuse, past and present, can all receive help and counseling.

"The goal is staying healthy, even if someone had experienced domestic violence in the past, they could be experiencing triggers, and getting counseling is better late than never," McCarthy said.

The largely Latino population served by the clinic is at greater risk of domestic violence because they are facing an especially challenging time in our nation's history, Purcell said.

"Their stress is through the roof with the political climate and the threat of deportation for loved ones," Purcell said. "We know stress for economically disadvantaged families can contribute to domestic violence."

It's hard for women to become a single parent or to lose their support network by moving so they suffer in difficult situations, she said.

"Fear of abandonment and loneliness, that's why people suffer in difficult situations," Purcell said.

Sometimes, women don't want to report abuse for fear of deportation for themselves or a member of their family, Purcell said. The doctor's office feels like a safer place to disclose the problem and seek support from there, she said.

"You don't get someone in an immediate crisis who got beat up the next day in primary care," Purcell said.

The clinic offers a Spanish-language help group once a week for patients who are experiencing domestic violence or survived it in the past. They hope to add an English-speaking one too.

"It's hard enough to say out loud in our own language, you are being abused, much less a second language," Purcell said.

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Every Thursday at 5:30 pm, there is a meeting at one of the clinics with about 15 women who share their experiences, celebrate successes and help each other through challenges.

Recently, the group held a baby shower for one of the women who had gotten out of an abusive relationship and was having a baby with her new partner with whom she had a healthy relationship.

"The group really become a kind of family, they celebrate things together," Lopez said. "They really are a supportive group."

Another woman, who is a domestic violence survivor, who is no longer with her husband, won full custody of her kids and has gone back to school. She attends the support group to be a resource for others, Lopez said.

For most patients, Purcell said, the victories aren't as dramatic but are still profound.

A patient who was depressed, suicidal, had four kids, and was still living with her abuser, also had a good job. She credits the support group for giving her enough strength to get up and go to work each day, Purcell said.

The patient was able to go on with her day-to-day life, got beyond the risk of suicide, and stays in touch with the clinic.

"Not going backwards is success," Purcell said. "If you can maintain the resources you do have, that is success. We have an open door policy and unconditional love. They can come when they want. Everything is unconditional. This takes a lot of patience to wait until they are ready."

As a result of the collaboration with MayView, Next Door Solutions has produced an online toolkit with step-by-step information and resources for how other organizations can work together to help patients get treatment for domestic violence in the healthcare setting.

Staff turnover is a challenge at the clinic, but each time a new staff member joins MayView they immediately go through a mandatory training on how to respond to domestic violence.

"It's important to make sure everyone is educated on domestic violence, on mandates for reporting and understands the goal is not to immediately call the police," McCarthy said. "You don't want a disclosure to trigger the staff and send the staff into a frenzy that makes the patient regret having decided to disclose the information."

If a staff member feels uncomfortable addressing domestic violence at any point, they can hand-off the patient to another provider, Lopez said. Prioritizing the issue at their clinic has even led many staff members to recognize and seek help for their own domestic violence situations.

"We were not prepared for how triggering it was for the staff," Henderson said.

For MayView staff, the subject hit especially close to home recently when one of their providers, Dr. Leann Watson Chadhar, was murdered by her husband in February of 2017. Her photo hangs in the waiting room at two of the MayView clinic sites. Sometimes people will ask about the photo and why it's there, which provides staff with another opportunity to discuss domestic violence openly and candidly with their patients.

"It can happen to anyone in any walk of life," Lopez said. "She wasn't able to get help but was trying to advocate for other domestic violence victims. She knew what needed to be done. It was an eye opener." ■