HEALTH SERVICES TOOLKIT

UNDERSTANDING NEEDS, INTEGRATING WELLNESS, AND EXPANDING HEALTH PARTNERSHIPS

A Guide for Directors, Advocates, and Front-line Staff
of Family Justice Centers and Multi-Agency
Domestic Violence Organizations

March 2015

FAMILY JUSTICE CENTER ALLIANCE

Creating Pathways to Hope
www.familyjusticecenter.org

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Introduction

The National Family Justice Center Alliance (“Alliance”) has helped develop and sustain over 90 Family Justice Centers (FJCs) across the nation offering co-located, multidisciplinary services to victims of domestic violence and their children across the United States. Stemming from the Alliance’s role as a national expert and resource center on strangulation assaults in domestic violence and sexual assault, and in anticipation of the evolving changes in healthcare, we have long-recognized the health needs and significant health consequences that victims of violence face. To address this area of need, the Alliance partnered with the **Blue Shield of California Foundation and the Verizon Foundation** to launch a Health Initiative with the goal of developing and testing viable models to integrate health services into the scope of care that Family Justice Centers provide.

The program elements described in this toolkit were pilot tested in the Van Nuys Family Justice Center in Northridge, California (North Los Angeles), and then further adopted and tested in various FJC settings. The Toolkit has elements designed for a wide spectrum of providers within FJC or similar multi-agency collaborative settings: Executive Directors, Operations Managers, Program/Project Managers, and advocates.

The purpose of this toolkit is to deliver findings from Alliance pilot studies to FJCs across the nation, and to help implement health assessments and health advocacy practices into client services, or “intake” (see the Alliance’s Client Services Toolkit), as well as develop medical, behavioral, and public health partnerships to address the whole health and wellness needs of survivors.

The content and strategies in this Toolkit were developed from a public health framework and trauma-informed perspective. This Toolkit is intended to fit within the Alliance’s standard of centralized intake/navigation, on- and off-site partnership makeup, and can be added into the Alliance Efforts To Outcomes template for sublicense holders. As the program elements and strategies described were pilot tested in select communities, other FJCs should adapt the elements to best fit their community needs, FJC culture, and scope of service.

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Framework

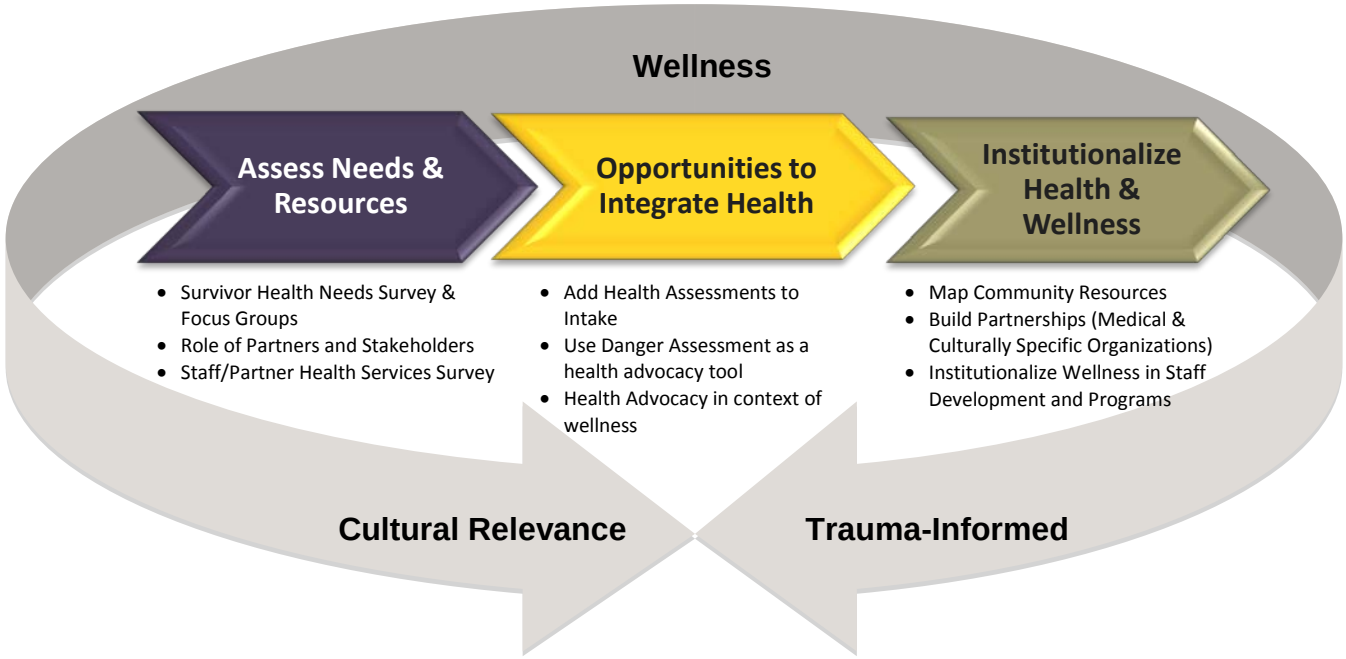
The Toolkit is based on the following Framework:

- ✓ **Part I, Assessment:** Provides tools and activities to assess survivor needs and organizational capacity so that each FJC is able to respond to their unique community makeup,
- ✓ **Part II, Organizational Tools:** Reviews key places within the centralized intake model of FJCs that health can be integrated, and
- ✓ **Part III, Program and Partnership Development:** Discusses strategies for developing or strengthening partnerships with the health sector to meet survivor health needs, as well as institutionalizing a framework of wellness.

Importantly, a framework of cultural relevance, trauma-informed care, and wellness runs through each section, just as they should be integrated into all FJC practices and partnerships. However, this Toolkit is limited to highlighting a few key culturally specific concerns and speaking through a trauma-informed lens. It is not meant to replace the practice of engaging survivors, communities of need, and service partners.

Culturally specific communities, such as communities of color, immigrants, lesbian, gay, bi-sexual, transgender, and queer (LGBTQ), and Native Americans, often experience system barriers that place them at greater risk for violence and its impacts. Therefore, engaging survivors and key representatives from these communities is the best way to develop practices that are truly sensitive and relevant for all.

Family Justice Centers are an important point of entry for survivors to multiple providers dedicated to serving the health, safety, and well-being of victims of IPV. Each FJC plays an important role in addressing the whole health needs – physical, emotional, psychological, social, and spiritual – of victims of violence, creating linkages to care and resources, and creating a place for healing. As such, the Alliance encourages that this Toolkit be implemented into FJCs as a living practice of survivor-centered health advocacy and trauma-informed care.



Thank You

The Alliance would like to thank its entire network of Family Justice Centers for supporting the Health Initiative and forging promising-practices in the arena of multidisciplinary and collaborative work towards wellness. This network, along with key faculty and advisors in the movement to end violence, have made the Health Initiative and this Toolkit possible. In particular, the Alliance thanks:

- **Kim Goldberg-Roth, Kathy Adams, Sheri Strahl and their staff and partners from Strength United and Van Nuys Family Justice Center for serving as the pilot site and providing key insights, thoughtfulness, and pioneering in this work.**
- **Jacquelyn Campbell for her support, research, and passionate consultation on this project.**
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- **Family Safety Center of Tulsa, Oklahoma**
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- **Family Justice Center Sonoma County**
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Background: Health Consequences of IPV

First, it is important to provide a brief overview of the health consequences of IPV to understand how health and safety - and therefore services - are experienced by survivors. This section primarily addresses the health consequences of women, not men, while also highlighting some key health disparities faced by communities of color, LGBTQ, immigrant women, and Native American women. For this purpose, the term “survivor” refers to survivors that are heterosexual women unless otherwise noted. For more extensive research regarding the intersection of health and violence for culturally specific populations, please refer to works citied in the Resources Page (**Appendix A**).

Global to Local: Costs of Intimate Partner Violence (IPV)
The global prevalence of intimate partner violence (IPV) and its effects, including high levels of femicide, persist despite decades of effort (Campbell, 2002). In the United States, IPV rates continue at alarming levels; one in four women will experience partner abuse in her lifetime; one in seven men (Centers for Disease Control and Prevention [CDC], 2013). Beyond the devastating impacts of violence to individuals, families, and communities IPV costs between $5.8 - $8.3 billion (CDC, 2013). This is not surprising given that a single domestic violence homicide in San Diego County cost up to $2.5 million in 1994 (Gwinn & Strack, 2010).

Health Consequences of IPV

Jacquelyn Campbell's original research linking poor health with IPV initiated a move to educate the health sector on IPV and provide routine domestic violence screenings that encourage both disclosure and appropriate service provision (Campbell, 2002). Unfortunately, routine screening has not been universally implemented and, conversely, the IPV field has only recently focused on its role in curbing health consequences (Hegarty et al., 2013).

IPV survivors generally self-report lower overall health than average (Plichta, 2004; Mathew et al., 2013), and may engage in more health-risk behaviors (e.g. poor diet, smoking, substance abuse) (Campbell, 2002). Beyond acute injuries from physical assault, survivors **experience chronic illness, sexual and reproductive health issues, and mental health problems** disproportionately from other populations. In addition, people who experience abuse both delay needed healthcare and utilize emergency departments and medicine with higher frequency.

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General Health

In the context of violence, there are multiple pathways to poor health: acute injury, chronic or persistent stress that lowers immune system defenses, delaying healthcare for minor injuries or co-occurring health needs, exacerbated co-occurring health or mental health needs, and risky health behaviors or coping behaviors (alcohol, smoking, drug use, etc.).

In particular, the chronic stress, inability to seek healthcare for health needs, and/or the delay of healthcare experienced by many can produce indirect and long-term health effects (Wuest et al., 2010). Indirect physical effects include central nervous system symptoms (headaches, fainting, back pain, seizures), and gastrointestinal conditions (e.g. irritable bowel syndrome, appetite changes, eating disorders). These indirect effects are widely attributed to chronic stress of managing an abusive environment, beyond any direct physical injury or trauma (Reisenhofer & Seibold, 2012).

Chronic Illness

Chronic diseases are long-lasting conditions that cannot be cured, but can be managed, such as heart disease, diabetes, stroke, cancer, obesity, and arthritis (CDC 2014). The Center for Disease Control and Prevention (CDC) reports that, combined, they are the "leading causes of death and disability in the U.S" (CDC, 2013). While chronic disease is major national issue for all women (52% of the general female population), women who have experienced domestic violence are significantly more likely to have a chronic illness than women who do not report abuse (88% in one study) (Verizon Foundation, 2013).

Similarly, while only 8% of all women report 2-3 chronic conditions, a national needs assessment conducted by the Alliance revealed that ***on average*** survivors report 2 chronic conditions, and many report more than three (Ward & Schiller, 2010). This suggests a higher prevalence of multiple chronic illnesses among survivors versus the general female population.

Managing chronic illness often requires dramatic behavioral change (i.e. diet, physical activity), as well as frequent doctor visits, medication adherence, etc. – equating to significant time and financial resources (structural barriers). Therefore, dealing in the intersection of health and IPV must be approached as an issue of access and from a perspective of systems change, rather than primarily relying on changing individual behavior and skills.

Missing the Connection

In a study on women entering a domestic violence shelter, almost half the residents reported needing to address health issues for themselves (Lyon, Lane & Menard, 2008). However, from a list of 38 needs, health ranked 19th. The Verizon Foundation (2013) survey also found that neither victims nor their health providers "are making the connection between chronic health conditions and domestic violence".

Reproductive and Sexual Health

Survivors are three times as likely to suffer from gynecological and sexual health problems as non-victims (Campbell, 2002). This is often due to forced sex, sexual assault, or sexual coercion that may accompany other forms of IPV.

There are two major concerns from forced sex: gynecological problems and the ability to control or negotiate reproductive and sexual health (for further reading: extensive research and activist work is available on the issue of **reproductive justice**).

Common gynecological problems include vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain, and frequent urinary tract infections (Campbell, 2002; Moya, Chavez-Baray & Martinez, 2014). Women who experience both physical and sexual abuse in relationships are at much higher risk of health problems than those who only experience physical abuse (Campbell, 2002). Screening for sexual assault and particular types of abuse are therefore vital for supporting the full scope of a survivor's needs.

Both physical abuse along with verbal degradation, control, and/or isolation also impact survivors' ability to make decisions regarding their sexual and reproductive health: stemming from an inability to or fear of receiving regular check-ups, to sexually transmitted infections (STIs) or HIV, to unwanted pregnancies, and even fetal injuries. Regardless of severity of abuse, therefore, sexual and reproductive health are very real issues for many.

Race, class, immigration status, and sexuality complicate a pure gender perspective to IPV (see Crenshaw, 1994 and Sokoloff & Dupont, 2005 for an overview of the intersectional framework, and review of the literature, respectively). This more nuanced and structural analysis is clearly demonstrated when looking at reproductive and sexual impacts of IPV. For example, one study in Texas used photovoice (equipping survivors with cameras to visually document and express their experience with violence) to reveal that role of motherhood, an emphasis on community vs. the individual, gender roles and marital expectations, and co-occurring experiences of immigration, acculturation, and racial-ethnic discrimination have multiplicative effects and complex intricacies when it comes to their experience of violence (Moya, Chavez-Baray, & Martinez, 2014).

Organizational structure and policies matter. States vary in how they support or limit access to women's health, particularly pre-natal and reproductive health care due to political controversies regarding birth-control and abortion. It is important to understand that survivor

FJCs and domestic violence agencies play an important role in creating meaningful links to care as well as advocating for needed services within the full-spectrum of healthcare needs at the policy level.

access to reproductive health care may vary from state to state and on other structural levels. FJCs and domestic violence agencies play an important role in creating meaningful links to care as well as advocating for needed services within the full-spectrum of healthcare needs at the policy level.

Children's Health

Camp HOPE, 2014

Children who are exposed to intimate partner violence (IPV) are also at risk of suffering adverse health outcomes. According to the National Survey of Children's Exposure to Violence (NatSCEV), the most comprehensive nationwide survey on the incidence and prevalence of children's exposure to violence, more than 1 in 9 (11%) children have been exposed to some form of family violence (physical or psychological violence) in the past year (S. L. Hamby, 2011). Harm to children who are exposed to IPV can include direct effects from the experience of witnessing abuse, such as physical injuries, as well as indirect effects from parenting that is compromised by abuse. However, all children exposed to IPV are affected differently and not all are traumatized. There are several factors that put children at risk for ongoing psychological and physical harm such as the severity, chronicity (duration and consistency), and frequency of abuse witnessed as well as the co-occurrence of other adverse experiences (Edleson, Gassman-Pines, & Hill, 2006).

Such direct exposure may produce immediate symptoms or even chronic long-term symptoms that last into adulthood. According to Hamby et al, 2010, 1 in 3 children who witnessed partner violence reported being physically abused themselves (S. Hamby, Finkelhor, Turner, & Ormrod, 2010). A host of impacts, from short to long-term, have been associated with exposure to IPV in studies conducting in the U.S. and European countries including: health complaints, specifically complaints related to eating, sleeping, pain, and self-harm (Lamers-Winkelman, De Schipper, & Oosterman, 2012); increased rates of mental health disorders such as post traumatic stress disorder, depression, and anxiety (Kitzmann, Gaylord, Holt, & Kenny, 2003; Lang & Stover, 2008; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003); negative externalizing behavior (problem behaviors such as disobeying rules, frequent distraction, bullying, threatening other children, vandalism, etc.) (Kernic et al., 2003), and increased risk of aggressive behavior (McGee & ebrary Inc., 2000). IPV can also have negative consequences by influencing the caretaking victim's parenting style, emotional availability and possible substance use (Holden, 2003).

The potential for a generational cycle of violence is the cornerstone to this discussion: evidence exists that children exposed to IPV are more likely to grow up to become a perpetrator or victim of domestic violence (Lichter & McCloskey, 2004).

Of particular note when planning programs or partnerships to mitigate the negative impacts of violence on children's health and well being is accounting for their resiliency and enhancing protective factors. In particular, supportive relationships with non-violent adults may offset the ill effects of exposure to IPV (Dalton, 2004). Because children exposed to intimate partner violence may not necessarily be direct victims of abuse, they may be overlooked by helping professionals and, therefore, the potential problems related to witnessing the abuse go unnoticed. Ignoring the consequences of exposure to violence on children can negatively impact their cognitive development as well as their emotional and physical health (Edleson, 1999).

Mental Health

Mental health needs remain a consistent area of need and is the most requested service amongst survivors (Alliance, 2014). Post-traumatic stress and depression are the most common and violence can either exacerbate chronic or already existing mental health issues, or act as the onset of symptoms (Campbell, 2002).

Alcohol and substance abuse is also related to IPV. While IPV does not necessarily ***cause*** alcohol or drug use, it is commonly associated with many health risk behaviors. The complexity of supporting a person who presents with co-occurring mental health or substance abuse needs demonstrates how important a wellness approach to advocacy, and having multiple medical and mental health partners within a community's arsenal of services is vital for those seeking help from abuse.

Mental health should also be considered in the context of physical care, whether in a healthcare or FJC setting. Among women who seek healthcare for issues related to abuse, they often report thorough physical care, but little or inadequate psycho-social support (Reisenhofer & Seibold, 2010).

We discussed chronic stress previously, but for minority populations the stigma and discrimination experienced as a result of racism or homophobia, to name a few, can exacerbate mental health effects above and beyond the social stigma of victimization. For example, LBGTQ populations are at greater risk for both depression and substance abuse than non-LGBTQ (Chen, Jacobs, & Rovi, 2013). Additionally, in three different studies reviewed by Rodriguez et al. (2009) 51% of Latina survivors compared to 14% of their white counterparts, 31% of African American survivors versus 14% of white survivors, and 40% of Native Americans experienced depression.

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They are also more likely to have experienced other forms of violence, and often have fewer resources at their disposal (such as culturally specific services or shelters). This should be a key area of intervention when attempting to integrate health services.

Emerging Evidence of Other Health Needs: Dental Health

Less data is available on the dental health needs of survivors, yet both researchers and practitioners stress the need for more research. One study reported that while 70% reported a dental need, only 13% of women in shelter were ever asked about their needs. Another study found that survivors had not seen a dentist in years and presented with needs ranging from dentures, extractions, restorations, dental prophylaxis, and dental education (Abel et al., 2012).

The Alliance Health Survey (2014) also revealed that 2 in 3 participants reported at least one dental concern, often a basic need such as cavities, tooth pain, or sensitivity. However, only 1 in 3 reported seeing a dentist within the last year. ***Dental as well as vision services were also among the most requested services for survivors.***

Health Utilization

Women experiencing severe physical or sexual abuse are more likely to seek formal help, and represent a significant portion of the numbers seeking care in emergency departments (Kramer, Lorenzo & Mueller, 2004; Reisenhofer & Seibold, 2010). However, survivor health needs as a whole remain unmet or underserved with ***9 to 22% of abused women seeking medical treatment at some point*** (Duterte et al., 2008).

Because survivors often delay health care, frequently utilize Emergency Rooms versus primary care, and have more expensive healthcare needs, their healthcare costs are over twice that of never-abused women. The national economic impacts are estimated at $8.3 billion annually, the majority of which are due to medical needs (CDC, 2013). For these reasons, healthcare settings have been targeted as a key point of intervention.

When, how, and why survivors decided to seek healthcare is also important. Research show that the process of deciding, determining trust and fit of services, and readiness dictate whether survivors will disclose abuse and seek follow-up (Catallo, Jack, Cilisk, & MacMillan, 2012). While extensive work has gone into enhancing the healthcare systems' capacity to serve survivors of violence, this fact underscores the need for increased collaboration between IPV and health sectors to build more innovative approaches for treating the whole person.[1] Beyond treatment, the health needs of survivors should also be considered as an issue of access and economic justice, as many often face restricted access, or take on the onus of payment, from abusers as well as from structural barriers such as hours of operation, cost, and insurance. Differentially low rates of seeking health care, as well as being referred to needed health care, exist for ethnic and racial minorities (Rodriguez et al., 2009). To illustrate, in one study 60% of Latina survivors versus 90% of white survivors sought health cares in the preceding year. In another, 48% of white survivors were referred to needed services, while only 26% of African American survivors were similarly referred. These factors, in tandem with any cultural values, use of informal supports (family, friends, community resources), language, religion, and acculturation all impact why, how, and when immigrant and ethnic or racial populations seek help (Buyan & Sentura, 2005).

Research overwhelmingly points to the role of partnerships, coordination, multidisciplinary teams, and inter-organizational collaboration of victim service as the best-practices in innovative services delivery for survivors (McGarry, Ney, 2006; Knoben and Oerlemans, 2006; Gewirtz, 2010; Munger, 2010; Gwinn & Strack, 2010; Uddin and Hossain, 2011b; Petrucci, 2013.

[1] It is because of the above fact that universal screening is recommended by the US Preventive Services Task Force and additional no-cost health coverage for women's health was included in the Affordable Care Act. Futures Without Violence has lead the way in this knowledge (see insert for resources).

FUTURES WITHOUT VIOLENCE

Futures Without Violence is a national IPV organization and partner of the Alliance that has done extensive work in the arena of healthcare access, training healthcare providers, and addressing reproductive coercion. Use the following links to access their information and resources:

- ✓ ***Health Cares About IPV***
- ✓ ***Project Connect***
- ✓ ***Reproductive Coercion***
- ✓ ***National Health Resource Center on Domestic Violence***

Integrating Wellness: Cultural Considerations

As noted earlier, this Toolkit uses the term “survivor” to refer broadly to survivors who are heterosexual women. Communities implementing this toolkit should carefully consider and understand all the populations served within their community. Women of color, immigrants, lesbian, gay, bisexual, transgender and queer (LGBTW) populations, Native Americans, immigrants, and other culturally specific populations have unique ways in which they experience and handle violence, and unique ways in which they think and engage with their health and the health sector.

First and foremost, include representatives from these communities and organizations that serve culturally specific population to serve on any planning committee. Each community has different sets of resources that only direct involvement can provide insight to.

Be open to having your assumptions challenged; assumptions about when, where, and how people experience abuse, and perceive systems and services. These challenges serve to foster true integration of services for survivors. An intersectional approach to IPV expands the traditional gendered violence perspective of IPV to the intersecting experiences of race, class, sexuality, religion and culture, and immigration status. All are 3-dimensional facets of a person’s identify, and therefore experience and perspective of abuse (Crenshaw, 1994).

The Alliance partnered with multiple culturally specific organizations to both review the toolkit as a whole and offer the perspectives and considerations that follow. We highly recommend practicing these perspectives as you implement health and all services.

- ✓ **Don’t let cultural relevance be an afterthought** or footnote. It should be integrated in formal policy as well as the cultural practice of your FJC.
- ✓ Think about the **impact of chronic stress** on culturally specific populations. This will help highlight survivors’ experiences of abuse from a partner, as well as their experiences of violence from community norms, systems, and structures. All of which contribute to a better understanding of viable (culturally relevant) services and strategies.
- ✓ Conduct a **review or audit** of your policies, procedures, and advocacy approach. Engage people from the communities you hope to serve to enhance them.
- ✓ Ask yourself whether or not your FJC staff, partners, and volunteers **reflect the community** in which you live and serve.
- ✓ **Represent a rural or geographically dispersed area?** Reach out to state or national organizations that work with culturally specific populations for resources, training, and technical assistance to enhance your ability to reach communities.
- ✓ Tap into the **assets of staff and partners,** and the communities they identify with, to enhance collaboration and services. See Part III: Institutionalizing Wellness for strategies to enhance staff health and wellness.
- ✓ **Do you know the entry points, change agents, or community leaders of the communities you hope to serve?** For example, many understand that to engage with law enforcement, an appreciation and respect for chain of command must be practiced. Be open and patient with the discovery process in each community you hope to engage.

PART ONE

Assessing Needs and Resources

As the health needs of survivors are vast, we recommend each FJC or multi-agency organization first conduct a mini needs assessment of

1) survivor priority health needs,
2) staff and organizational readiness, and
3) community assets and resources.

The information gathered will not only help planners and program staff best address the needs of survivors, but can also be used later to frame needs and program ideas when forging new health partnerships.

Understanding Survivor Health Needs

Surveying Needs

A survey of health needs is useful in gathering comprehensive data on particular health concerns of survivors. For example, the Alliance conducted a national survey of survivor health needs in 2013 and found that basic vision and dental health services were major needs; disproportionate even from low rates of primary and mental health care.

The survey can be found in **Appendix B** in both English and Spanish. It was adapted from the Behavioral Risk Factor Surveillance System (BRFSS), a national survey developed by the CDC, used to gather data on a vast array of physical, mental, and behavioral health needs nationwide. The BRFSS has been validated on multiple populations making it an appropriate tool to lend to a full health needs assessment such as this.

The Alliance Health Survey captures:

- ✓ **Survivor health needs or concerns: Physical, sexual, mental, dental, vision, behavioral, and preventive health**
- ✓ **Survivor access and barriers to healthcare**
- ✓ **Survivor desires for FJC-integrated health services**

The Alliance recommends that FJCs and other multi-agency organizations conduct this survey in conjunction with a focus group (see below), as well as a brief assessment (or mini-audit) of organizational readiness to address health needs. The survey is designed to be conducted with first-time clients as well as with survivors receiving ongoing services in order to generate a complete scope of needed services. It can be administered by an advocate or navigator during check-in or the "intake process", with support groups or other partner program activities. It is imperative to respect a survivor's experience when accessing services, whether for the first time or for ongoing services. Therefore obtaining consent during the service delivery or exit interview process, then conducting the survey with clients during a follow-up call or visit may be the most appropriate. A clear explanation of the purpose and use of the survey is important, especially given the extensive paperwork and forms many survivors are asked to complete when visiting a Center

Analyzing Survey Data: What to Look For?

The Alliance Health Survey Report findings are a helpful starting point. See the infographic insert as a basic summary of findings. For further details, please see the full Health Survey Report.

Once all surveys are completed, answers to the following questions can be easily found within your survey data by using averages and other descriptive statistics easily obtained from Excel spreadsheets or from pulling reports in many database software systems:

Questions for Analyzing Data:

- ***Do survivors accessing our services have sufficient health insurance coverage?***
- ***Do they have a primary care doctor? Do they see them regularly?***
- ***What are the primary health concerns of survivors accessing our services? Physical, mental, sexual/reproductive, behavioral, preventive? What are the specific concerns with in each type of health?***
- ***What are the primary barriers to care?***
- ***How are survivors prioritizing their health needs?***
- ***What are the survivor-identified opportunities for the FJC to provide health services?***
- ***Are there big differences in health needs between those who have insurance and those who do not?***

Health Needs of Survivors in Family Justice Centers

In October 2013, the Alliance surveyed 240 survivors in 14 Family Justice Centers Across 11 states.

This is what we found...

Survivors are not getting the healthcare they need.

7 in 10 reported AT LEAST ONE physical health need.

ONLY 3 in 10 saw a primary care doctor in 2013.

But HALF went to the Emergency Room.

They have multiple health needs...

32% reported sexual or reproductive issues such as urinary tract infections or sexually transmitted diseases.

45% reported a chronic health condition such as diabetes or asthma.

70% reported health needs such as headaches, fatigue, constant pain, high blood pressure, etc.

And unique health needs.

DENTAL AND VISION represent the highest needs

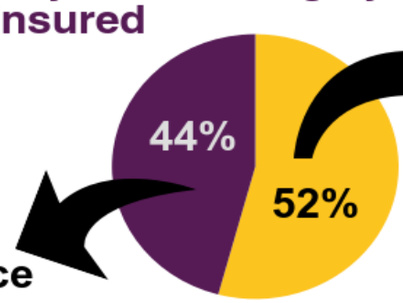
60% and 50% report basic needs

...are the most requested services...

nearly HALF request dental and vision services

But present the MOST BARRIERS TO CARE

Survivors surveyed were largely un- or under-insured



mostly public insurance

65% public, 32% through self/spouse employer, 2% military

no insurance

All of them were seeking services in a Family Justice Center

Make your FJC a place of wellness, linkage to care, and a pathway to healing for all.

Find out more at www.familyjusticecenter.org or contact sara@nfjca.org about implementing a Health initiative in your FJC.

Focus Groups: Overview and Purpose

Focus groups offer an important way to better understand survivors' experiences of health and wellness within the full context of their lives. The following focus group guide is geared towards both health and wellness, in an effort to understand both major health needs along with an understanding of how survivors connect their health to their sense of safety. Finally, focus groups provide a unique opportunity to strategize with survivors about how best to meet all their needs.

While many in the DV movement have been practicing victim-centered services, advocacy, and "trauma-informed care", new research and thought on Trauma-Informed Approaches to IPV articulates how violence is just one aspect of each person's complex set of needs, experiences, and identity. ***The key to integrating health services within an FJC's scope of services is not only to provide healthcare onsite, but to consider their health and well-being at every turn.***

The **Full Frame Initiative** has recently challenged domestic violence service organizations to re-approach their work through an understanding and advocacy within the Five Domains of Well-being: Connectedness, Stability, Mastery, Safety, and Meaningful Access to Resources. The formative work of the Alliance in developing Family Justice Centers across the U.S. was grounded in very similar principles. ***In particular, the use of extensive focus groups with survivors showed that social networks and meaningful interaction with service providers (not necessarily the service itself) was most valuable and helpful to survivors' journeys*** (Gibson, 2008). From here, the Alliance developed its Guiding Principles and the work of the Health Initiative is in part a mission to deepen integration in FJCs to foster a trauma-informed approach across any and every sector of service a person may need when dealing with violence.

The purpose of this Focus Group Supplement is to help FJCs understand health needs, but it is primarily to understand how survivors view and experience health and wellness within the whole context of their lives. Then a Center can do the work of serving a person's health and other needs so that they best support their overall wellness and safety. Conducting these Focus Groups should help FJCs consider how to both implement health services as well as how to implement a framework of wellness into its entire service delivery model.

Please see the ***Alliance Focus Group Toolkit*** for in-depth explanations on how to organize and conduct a focus group with survivors.

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Conducting Focus Groups

Some key considerations for holding focus groups include:

- **Limit the focus group to 8-12 people.** Hold multiple focus groups if you have more than 12. This allows each participant an opportunity to share experiences equally.
- **Focus groups generally last 1 – 1.5 hours**. Depending on the depth of your discussion, suggest a follow-up focus group with participants so highlighted themes can be discussed more in depth.
- **Offer child care, transportation assistance, snacks, and a small incentive for their participation**. They are giving you important insight that should be acknowledged!
- **Have a facilitator and separate note taker** (so the facilitator can focus mostly on guiding the conversation). The facilitator should NOT be anyone the survivors are receiving services from, but a person both comfortable with talking about abuse and health issues, and a person independent from the survivors' case management. An exception might be to hold a focus group with a regularly occurring support group. The point is to acknowledge the potential for power differentials and to make the environment as welcoming, easy, and open for the group of participants.
- **Focus groups should by fairly homogenous:** hold English and Spanish speaking groups separately, for example, in order to ease coordination and participant comfort in sharing experiences.

When beginning a focus group, remember to:

- **Explain confidentiality, obtain verbal and written consent, and explain the purpose of the group**
- **Facilitate introductions among participants**
- **Offer a participant guide: An opening activity on the topic is often a nice ice-breaker**
- **Have a list of questions and a script handy. We have provided a fairly structured interview guide so that most facilitators can feel at ease. Facilitators may loosen the structure or adapt questions based on their experience, comfort, purposed of the focus groups, and the comfort of the group**
- **Describe the facilitator's role explicitly to the group**

See Alliance Focus Group Toolkit.

- **Letters of Confidentiality and Consent** should be thoroughly described both verbally and in writing for participants so they understand how the information will be used, are assured of its independence from their services, and can be engaged in further survivor-centered activities
- **Write the purpose, objectives, and/or key questions on a black/white board**, flipchart, or provide as a handout so that participants are aware of the discussion to take place. Some people also like taking notes, writing thoughts or comments, or simply doodling as they participate in discussions. This serves to address 1) all level of literacy, as well as 2) all types of learning and personality type to enhance inclusivity.
- **The facilitator is just that – someone making sure the conversation stays on track,** that major questions are asked, answered, and clarified when necessary. They should not lead the conversation, offer solutions, or pass judgments, but they should also be a natural speaker and the person who both sparks and manages discussion within the group.

Alliance Health and Wellness Focus Group Supplement

This guide is for a structured focus group so that it can be conducted by various people and levels of experience. A structured guide means it can be read as a script by the facilitator. Having basic group facilitation and meeting management skills, appropriate language skills (i.e. be able to speak Spanish if the group is Spanish speaking), and knowledge and comfort talking about sensitive issues. It is important to note that this is not a support nor a service delivery group, this is particularly important to relay to participants who may be actively receiving services – participation in the group will not impact any services they are receiving.

Also of note, the focus group questions were designed for a FJC who has not yet established health or medical services. If an **FJC is looking to get feedback on current or active health services, some questions may still be appropriate from this guide, but more specific questions related to a given program or partner's services may also be necessary.** Refer to any project or program goals, medical/health partners, or reach out to the Alliance to determine the best questions.

The complete supplement is available in Appendix C.

Script and Questions

1) What does being "healthy" mean to you?

2) What does "wellness" mean to you? Is it different than "health"?

3) Do you feel that you are healthy? Well?

4) Before coming to the FJC, did you have any health concerns?

5) As much as you feel comfortable, can you describe how you handled your health needs in your relationship?
   Probe: Did the violence impact how you handled your health needs?

6) When you first came to the FJC, were you able to address or talk about any health needs?
   Probe: Was this a priority for you? Is addressing health important to you?

7) Do you think it's important for the advocates and other partners here to ask people about health?
   Probe: If so, how would you like people to talk with you about health or wellness when coming in for services related to domestic violence?

8) Is there anything the FJC can do or do better to support your long-term health and wellness?

9) Are there any barriers or issues you have currently that make it difficult to address your health concerns?

10) If health services, like general check-ups, vaccines, cholesterol checks, etc., were offered here at the FJC, would you come for services?

11) Is there anything else you'd like to say about your experience of health and violence?
   Probe: Anything you think FJCs can do to best support the long-term health and wellness of survivors?

Analyzing Focus Group Notes and Transcripts

The following steps are ideal for the most thorough and thoughtful group analysis of the Focus Group. At a minimum, complete Steps 1, 2, 3, and 5. It is important to first review major insights gained from the Focus Group alone and then discuss findings alongside both survey results and any organizational assessment findings before moving on to design programs or plan services.

Step 1. As you conclude the Focus Group, the facilitator should summarize key themes or take-away points they gathered from the discussion. Then ask participants for feedback and what primary messages the facilitator should take back to FJC staff as they plan for health services.

Step 2. The facilitator and note-taker should immediately write down their reflections and thoughts from the Focus Group. This should be separate from any notes taken during the Focus Group. This can be sent as an email, saved as a Word Doc or memo, or handwritten. Consider everything from how the group was organized and dynamics of the group, to what ideas, experiences, and common themes emerged from the discussion.

Step 3. The facilitator and note-taker should meet within one or two days after the Focus Group to debrief and verbally compare notes.

Step 4. If the Focus Groups were recorded, have them transcribed by staff, interns, or volunteers.

Step 5. If a Planning Committee has not already been organized, take this opportunity to do so and convene a meeting to debrief about the Focus Group, review notes, discuss Step 6, and plan next steps.

Step 6. If recordings have been transcribed, task each member of the Planning Committee to read through the transcript and highlight any standout themes. The same can be done with detailed notes from the Focus Group if recordings are not available. Examples of themes to highlight might include:

- Definitions or explanations of both “health” and “wellness”.
- Any comments related to survivors’ perception of health status.
- Any specific health needs or concerns.
- Quotes or comments related to experiences addressing their health within abusive relationships.
- Comments related to how to “prioritize” health and how they have been and should be “treated” regarding health.
- Comments related to “barriers” with health both in the community seeking healthcare as well as onsite at the FJC.
- Comments or stories about how they can best be supported.
- Comments about ideas, strategies, or services for the FJC to provide regarding health.

Step 7. The facilitator or assigned project leader should review all notes and findings, and convene another meeting to finalize major findings and strategize next steps.

***Note: A VOICES Committee member or survivor should be on the Planning Committee or at this point be asked to review final notes, findings, and provide feedback on action steps determined by the Planning Committee.**

What can be done with Focus Group findings?

- ✓ **Report out at Partner meetings**
- ✓ **Include findings in your Annual Report**
- ✓ **Create a special Report on findings and release to the community**
- ✓ **Hold a Community Forum with survivors, partners, elected officials, potential partners, and the general public to present findings as well as present or propose FJC initiatives**
- ✓ **Use them in program planning to decide what services best fit your community’s needs and how to implement them**
- ✓ **Present findings to potential partners during meetings when garnering buy-in and when drafting partnership agreements**

Spotlight: Findings from Essex County FJC Survivor Focus Group

Key Findings

What does "health" mean to you?

- Not being sick or not having a disease
- Being connected to family and friends
- Having medical and spiritual support
- Being able to handle stress
- Not feeling alone

How can the FJC better support your long-term health and wellness?

- Stay connected and provide the services I need: civil-legal, housing, primary health, self-sufficiency.
- Help with access and basic needs: bus tickets, grocery/food assistance

What does "wellness" mean to you?

- Freedom
- Being happy with myself
- Not having to run and hide
- Being secure and stable
- Being able to control my life, get needed services, talk with my children, and be financially independent
- Feeling safe and being treated as an equal

Emerging Themes and Takeaways

Survivors intimately link their psychological and spiritual well-being and sense of safety to their overall health and wellness.

Providing for survivors' health goes beyond medical services – it means understanding their complex needs and linking them to care.

Participants agreed that being connected and receiving meaningful services had a direct impact in both short and long term wellness. Expanding health services in FJCs must be a process of integrating wellness both through comprehensive, coordinated services and through the FJC culture.

Assessing Family Justice Center Capacity

As in all collaborative work, preparing other partnerships for the inclusion and integration of new services is key. Assessing your FJC's readiness can take many forms, from informal to formal:

- **Hold a meeting with partners to discuss health needs, barriers working with (professionally) or referring survivors to healthcare resources, comfort in addressing health, and action steps.**
- **Hold a meeting between current partners and community health resources to discuss partnership needs, gaps in care, and action steps.**
- **Hold meetings with frontline staff regarding what they see in terms of health/medical needs, gaps and barriers, potential partners or training needs, and action steps.**
- **Survey current onsite partners and staff regarding experience, needs, and readiness for health integration.**

ALLIANCE HEALTH SERVICES SURVEY

Spotlight: Van Nuys FJC Counselor Survey Findings

✓**Most felt confident** in their ability to discuss health needs,
✓However, the **majority "hardly ever"** discussed vision and dental needs
✓And the **majority "sometimes"** discussed physical health needs**;**
✓The **majority "disagreed"** that survivors get the health they need.

In contrast, during a national webinar hosted by the Alliance, we surveyed medical providers on the same question and most felt that care **IS READILY** available to survivors.

What does this mean? Counselors and advocates are capable of discussing and serving health concerns, but basic training and institutionalization of wellness is necessary, along with establishing meaningful and trusted links to health care providers.

Below is a sample "Health Services Survey" available for use with partners. Surveying staff and partners may be helpful in identifying discussion points. It is also available in **Appendix D**.

For example, throughout the pilot project with Van Nuys Family Justice Center, we heard from advocates that while they were comfortable and confident in discussing many issues with survivors, they were less confident about identifying, assessing, and linking survivors to healthcare. They also strongly agreed that health should be a priority and was important to survivor safety, but explained that services were not readily available. This was reflected organizationally in referral rates and reiterated during in-depth interviews.

Connecting with advocates gave leaders insight into addressing health on two fronts: 1) internal staff training and capacity building, and 2) strengthening current health partnerships and identifying new partners.

Assessing the health needs and organizational readiness provides a great platform to:

- Present data to potential health partners
- Identify most needed health services, opportunities for cross-training, and developing partnership MOUs.
- Engage current partners and staff in creative solutions to promote wellness
- Engage survivors in directing the role of health partnerships
- Understand how to best fit and implement health and wellness into current practice

COUNSELOR HEALTH SERVICES SURVEY

We are interested in expanding health and medical services for victims at Valley CARES Family Justice Center. This survey will help us understand staff needs, develop future programming, and assess client outcomes. We appreciate your participation. Please answer the following questions to the best of your ability.

This survey is completely confidential.

DEMOGRAPHICS

1. How long have you been working at Valley CARES Family Justice Center?
☐ less than 3 months ☐ 3-6 months ☐ 6 months to 1 year ☐ over 1 year

2. What type of training have you received?

☐Domestic violence	☐ Safety Planning
☐Sexual assault	☐ Danger/high-risk Assessment for DV
☐Elder abuse	☐ Health consequences of violence
☐Child abuse	☐Strangulation identification and/or assessment
☐Law enforcement protocols/policies	☐Other:_____

3. Do you have any prior experience working/training in healthcare settings (social work, medicine, nursing, etc.)?	☐Yes, Describe_____ ☐No ☐Not sure
4. About how many clients did you see in the last week?	#_____
5. Of these, how many were follow-up visits (not the first visit)?	#_____

2. HEALTH SERVICES

1. If someone you're speaking with has a health/medical need **WHO** do you refer them to? (list or check "Not sure")	Name/agency_____ ☐ Not sure

2. How often do you discuss the **dental** health needs of victims)?
☐ Almost never ☐ Rarely ☐ Sometimes ☐ Regularly/often

3. How often do you discuss the **vision** health needs of victims?
☐ Almost never ☐ Rarely ☐ Sometimes ☐ Regularly/often

4. How often do you discuss the **physical (non-acute)** health needs of victims?
☐ Almost never ☐ Rarely ☐ Sometimes ☐ Regularly/often

5. How often do you discuss the **mental** health needs of victims?
☐ Almost never ☐ Rarely ☐ Sometimes ☐ Regularly/often

3. I agree with the following statements (1=strongly disagree, 5=strongly agree)…

1. The health needs of DV survivors should take priority.
1 2 3 4 5

2. I feel confident in my ability to identify physical health needs of a client.
1 2 3 4 5

3. I feel comfortable bringing up discussions of health with clients.
1 2 3 4 5

4. Clients I work with think addressing their health needs is important to their safety.
1 2 3 4 5

5. Health needs should be included in safety planning.
1 2 3 4 5

6. Colleagues or FJC partners are readily available to assist with the health needs of clients.
1 2 3 4 5

7. The majority of victims I work with have experienced some type of physical violence.
1 2 3 4 5

8. Victims I work with will follow-up on needed medical/health services.
1 2 3 4 5

9. In general, victims get the healthcare services they need.
1 2 3 4 5

10. There are good healthcare services available to clients I work with.
1 2 3 4 5

Thank you for completing this survey!

PART TWO

Opportunities to Integrate Health

A rule in expanding services, implementing new programs, or adopting a new approach to current practices is to keep it organizationally simple! As FJCs are the collaborative unit of any one community's partners and resources, looking to the centralized intake process is key.

This next section reviews the Alliance's centralized and choice-based intake protocol and highlights where health and wellness can be integrated, providing practical tools, guides, and forms where applicable.

The Danger Assessment Health Checklist is the key tool developed by the Alliance, intended not only to encourage use of the Danger Assessment in risk assessment, but to initiate thorough and wellness-centered advocacy and safety planning.

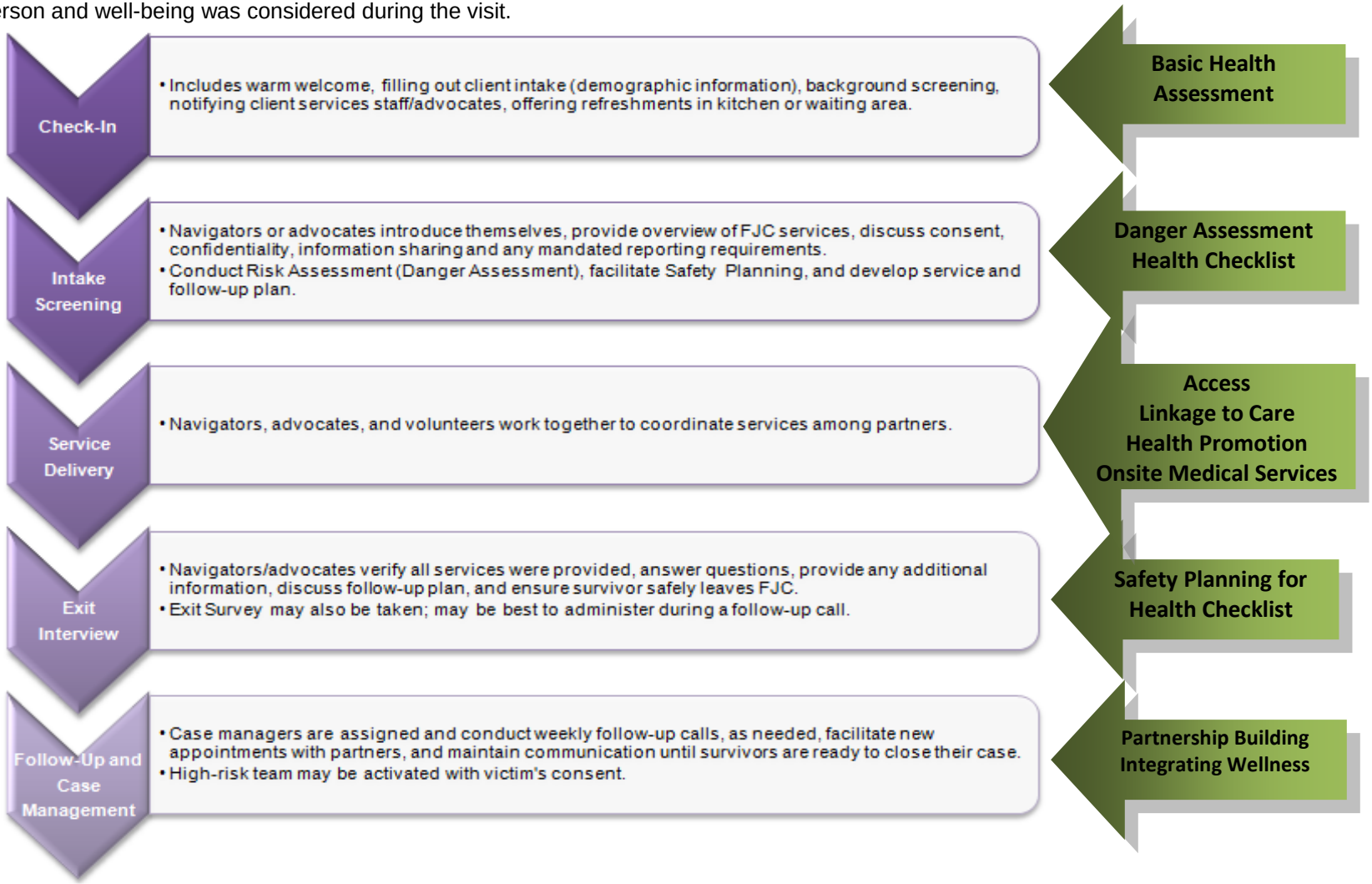
Opportunities to Integrate Health

Family Justice Center Centralized Client Flow Process

This work is rooted in a trauma-informed and survivor-centered approach in an effort to make "service delivery" come alive and to be held accountable to survivors. The key elements discussed should lead to improving access to healthcare, ensuring safety, linking and navigating people to care, and promoting health. The goal is that every survivor walk away from the FJC feeling like their whole person and well-being was considered during the visit.

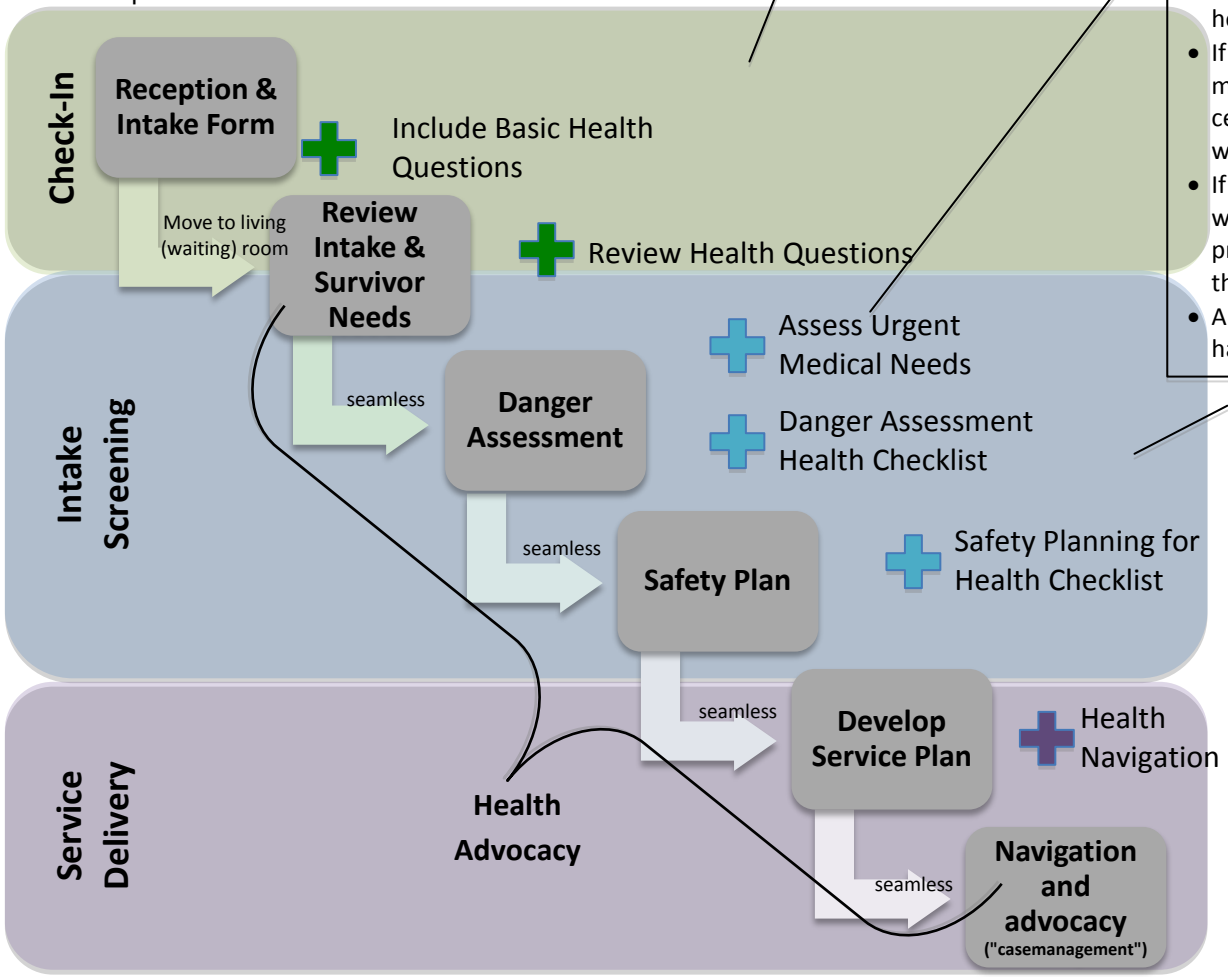
The client-flow process through a Family Justice Center is as follows. See the ***Alliance Client Services Toolkit*** for more details.

Opportunities to integrate health can be found along this same flow (green arrows), thereby integrating health and wellness into the backbone of the partnership.



Breaking It Down: Opportunities & Considerations

For the purposes of this toolkit, three phases of the centralized client intake system will be highlighted in this section: Check-in, Intake, and Service Delivery. These phases will allow an emphasis on how health tools can be integrated into FJC and multi-agency service delivery protocols, for the purpose of addressing health needs and enhancing survivor-centered advocacy. Breaking down this first "phase" of service delivery, the process and supplemental health components follows this flow:



Considerations:

- Is your reception a welcoming place?
- The scope of health questions added should create an intake form that captures a complete hierarchy of needs (Maslow's Hierarchy).
- All FJC partner agencies should be able to utilize one central intake form.
- All services should be reflected in the intake form in that partners exist to fit survivor needs, not that a survivor's experience is prescribed by available partners
- Intake forms (with health questions) are completed at reception, then reviewed with an advocate/navigator once the intake and advocacy process begins.

Considerations:

- Do you have trusted on and off-site partners that can meet the health needs discussed by survivors?
- If a survivor reveals, or an advocate becomes concerned about, a medical urgency or emergency, do you have a safe, survivor-centered protocol in place to get them needed health care as well as continue support for their full context of needs?
- If you are a medical mandated state, do you have a relationship with Law Enforcement that will allow for a trauma-informed provision of medical care and any criminal justice proceedings that may follow?
- Are advocates and navigators trained, feel comfortable, and have the autonomy to assess and address health needs?

Considerations:

- Overall Risk and standard DA protocol should be conducted first.
- Following up on health needs should be included in the overall context of needs of a survivor. For example, with education and advocacy, a health concern may become a high priority; on the other hand, a health concern may be better addressed during follow-up once basic needs are met.
- Are advocates/navigators trained to think about what the trade-offs to addressing health, if any, might be (for example, abuser cancelling insurance, time off from work).
- Is there enough time for advocates/navigators to work with survivor's needs? Is your follow-up process effective at addressing other needs?

Including Basic Health Questions

Including a brief health assessment requires adding a few general health questions to the centralized intake form. Recruiting a current forensic or medical partner to identify key questions can be a helpful starting place. View this complete form in **Appendix E(i)**.

The Alliance spoke with forensic nurses, FJC Directors, advocates, survivors, and health professionals at the Pilot Site to create a generic list of questions for intake. The purpose of these questions is to 1) establish a baseline of need for survivors, and 2) identify the prevalence of known gaps in healthcare. Through case management and data management, these statistics can be tracked, examined, and changed throughout the survivors' time with the FJC.

What do we add to our intake form?[2]

- **Major Medical/Health Referral source(s) (Note: Get to know healthcare providers in your community!)**
- **Have you been to the Emergency Room in the past 12 months?**
- **Do you have a primary care doctor? Date of last visit?**
- **Do you currently have health insurance? (type)**
- **Do your children have health insurance? (type)**
- **Would you like help enrolling in health insurance?**
- **Are you concerned you might be pregnant?**
- **Would you like to see a doctor/nurse about any health issues today? Future?**

More Advanced

- **Do you have any medical condition you are currently being treated for?**
- **Are you taking the medication? Do you have the medication with you?**

[2] See Futures Without Violence for more on the role of health assessments in advocacy.

SAMPLE HEALTH INTAKE ASSESSMENT QUESTIONS
(add to Intake Forms)

Referral Information

Who referred you here today? *(referral sources in red should be added in addition to complete list)*

☐ No one

☐ [On-site Health partner agency]
☐ Social Worker (E.g. Dept. of Children and Family Services)
☐ Family member
☐ Friend
☐ Neighborhood Legal Services (NLS)
☐ Primary Care Physician/ Psychiatrist
☐ [Off-site Health partner agency]
☐ Therapist (Psychologist, Licensed Clinical Social Worker, Marriage and Family Therapist)
☐ Police
☐ Other (please specify): _____

Basic Health Information	
Have you been to the Emergency Room (ER) in the past 12 months?	☐**Yes** ☐**No**
Do you have a primary care doctor?	☐**Yes** ☐**No**
If Yes, Date of last visit:_____ / _____ / _____	
Do you have health insurance?	☐**Yes** ☐**No**
Are your children insured?	☐**Yes, under my insurance plan (please list names):** _____ ☐**Yes, under a different plan (please list):** _____ ☐**No or not sure.**
Are you pregnant?	☐**Yes** ☐**No** ☐N/A
Are you concerned you might be pregnant?	☐**Yes** ☐**No** ☐N/A
Health Services and Other	
Do you have any health needs (dental, vision, physical, mental) that you are concerned about?	☐**Yes** ☐**No** **Explain if yes:**
Do you have any medical condition you are currently being treated for? (see a doctor regularly or take medication regularly)	☐**Yes** ☐**No** ☐N/A
Are you taking the medication?	☐**Yes** ☐**No** ☐**N/A**
If yes, do you have the medication with you?	☐**Yes** ☐**No** ☐**N/A**
Would you like help enrolling in health insurance?	☐**Yes** ☐**No** ☐**N/A**
Would you like help making an appointment to see a doctor/nurse about any health concerns?	☐**Yes** ☐**No** ☐**N/A**

Reviewing the Intake Form and Assessment Questions

After completing the intake form, a survivor should be guided into a waiting room where an advocate/navigator will then come lead them into a private room to review the intake form and begin the intake process. Asking about survivor needs, reasons for coming, and any goals should always take priority.

Regarding the health questions, this is a good opportunity to begin education about why health needs are included and initiate discussion about any health needs.

In addition to reviewing the health questions on the intake form and beginning to discuss any gaps, there are three questions that may be important to begin assessing acute injuries or medical emergencies.

The Alliance recommends not including these in the intake form, to avoid non-response, but to instead develop a protocol for advocates to ask the following questions during the initial review.

1. **Have you had unprotected sex in the last 72 hours?**
2. **Have you been strangled/choked (someone putting their hands, body part, or object around your neck) in the last 72 hours?**
3. **Have you been punched, kicked, or otherwise hurt in the head (slammed against wall/ground) in the last 72 hours?**

PROGRAM SPOTLIGHT: TULSA FAMILY SAFETY CENTER NURSE FORENSIC CHECKLIST

As an integral part of the Client Intake process, the Tulsa Family Safety Center has implemented a "Forensic Nurse Examiner Services" assessment tool. Each new client, and returning survivors who have new incidents to report, complete a brief set of questions that capture injury, pain, pregnancy, self-harm or suicide ideation, medication history and contextual factors (i.e., age and children). The forms are immediately reviewed by a full-time, onsite forensic nurse. Based on the response, the nurse determines if there are any emergent health needs to address before legal advocacy is initiated/completed. At the Family Safety Center, nurses conduct forensic medical examinations, complete the Danger Assessment, conduct health safety planning, then link survivors back to additional health/medical services and advocacy to address any other needs.

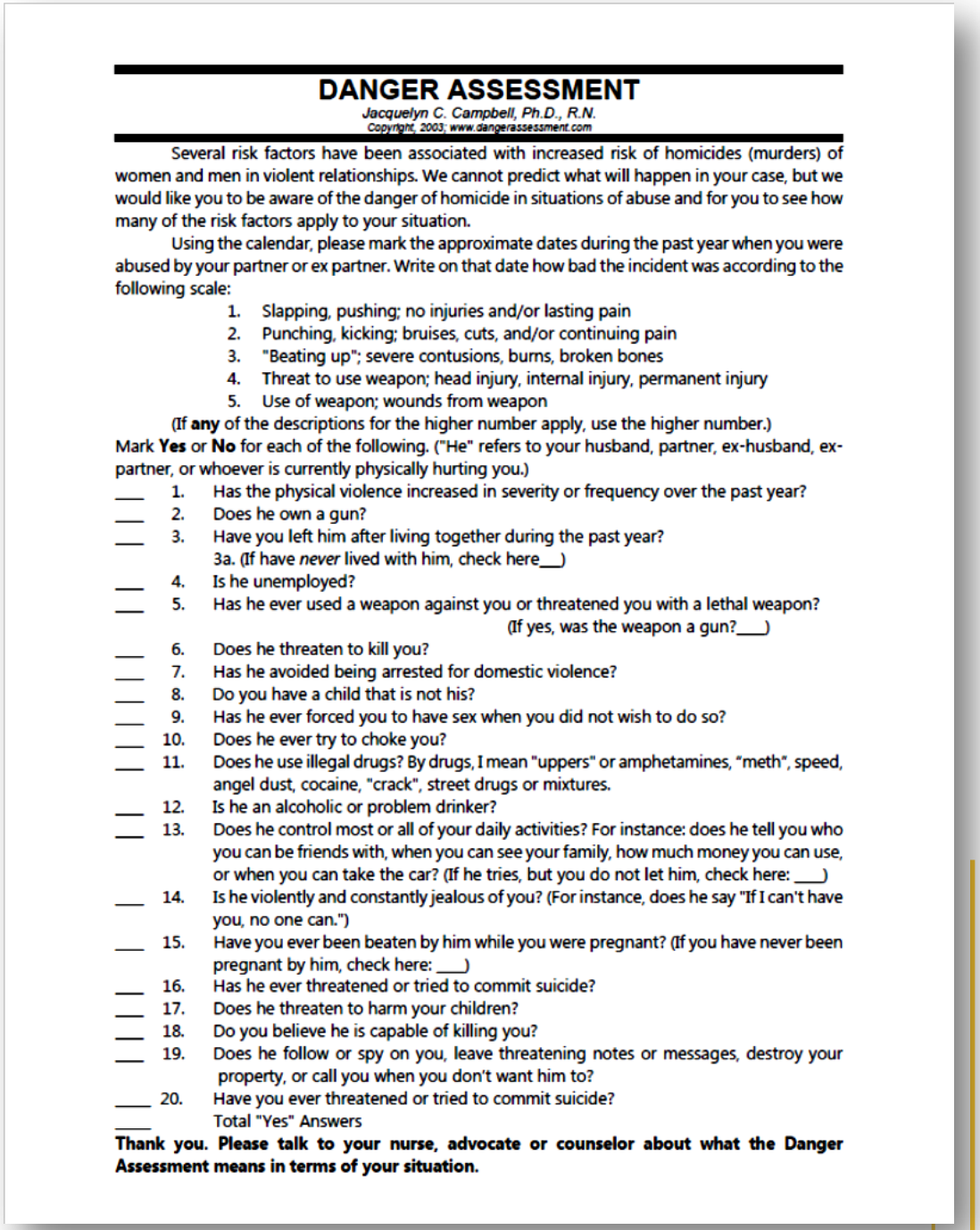
***A sample of the Forensic Nurse Checklist is available in Appendix F.**

From the Danger Assessment to Health Advocacy

A key component to integrating health services is through the advocacy and safety planning, leading to service coordination, available at a FJC. Given the existence of multiple, co-located partner agencies, and the collaborative culture of FJCs, the Alliance has recommended the use of the Danger Assessment (Campbell, 2003) during the centralized intake process. The Danger Assessment was developed by Jacquelyn Campbell in 2003 during her seminal research on IPV homicides and the long-term consequences of IPV. It was designed to be administered by advocates, medical professionals, and other lay IPV professional to 1) identify a survivor's level of risk through a 20 question checklist and a calendar, and 2) guide safety planning.

Dr. Campbell offers certification for delivering the Danger Assessment. See the website and register your FJC staff and partners to receive the training. http://www.dangerassessment.org/TrainingOptions.aspx

The structure of FJCs creates a "built-in" high-risk team and the Alliance advocates for the use of the Danger Assessment in mobilizing partners to protect victim safety. The ***Danger Assessment Health Checklist*** was designed to focus on the safety planning, and whole person care of survivors.



DANGER ASSESSMENT

Jacquelyn C. Campbell, Ph.D., R.N.

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Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

___ 1. Has the physical violence increased in severity or frequency over the past year?
___ 2. Does he own a gun?
___ 3. Have you left him after living together during the past year?
3a. (If have *never* lived with him, check here___)
___ 4. Is he unemployed?
___ 5. Has he ever used a weapon against you or threatened you with a lethal weapon? (If yes, was the weapon a gun?___)
___ 6. Does he threaten to kill you?
___ 7. Has he avoided being arrested for domestic violence?
___ 8. Do you have a child that is not his?
___ 9. Has he ever forced you to have sex when you did not wish to do so?
___ 10. Does he ever try to choke you?
___ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, "meth", speed, angel dust, cocaine, "crack", street drugs or mixtures.
___ 12. Is he an alcoholic or problem drinker?
___ 13. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ___)
___ 14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
___ 15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ___)
___ 16. Has he ever threatened or tried to commit suicide?
___ 17. Does he threaten to harm your children?
___ 18. Do you believe he is capable of killing you?
___ 19. Does he follow or spy on you, leave threatening notes or messages, destroy your property, or call you when you don't want him to?
___ 20. Have you ever threatened or tried to commit suicide?
___ Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

Danger Assessment Health Checklist: How It Works

The questions on the ***Danger Assessment Health Checklist (Checklist)*** are a guide for advocates, medical personnel, and other IPV professionals to discuss any potential medical health risks based on responses to the Danger Assessment. Based on findings from the Alliance pilot study, many advocates and IPV providers stated they are very comfortable assessing risk and identifying safety and even mental health issues, but they are less familiar with what and how to ask about physical health issues. It is not the role of advocates to take on deep medical knowledge, but many express both a need and desire to build confidence in talking generally about health needs with survivors they work with.

The format for delivering the Checklist was modeled after the American College of Obstetricians and Gynecologists (ACOG) recommendations for healthcare providers in screening for IPV. These recommendations include: a framing statement, discussing/clarifying confidentiality, and sample questions (for healthcare providers reading this Toolkit, see **ACOG's recommendations**).

Once the Danger Assessment is completed, the advocate should address the overall risk as they were trained to do in the DA certification. Then, advocates should again review which questions the survivor check as "yes". Based on "yes" answers the Checklist provides additional health-related questions that further assess 1) injury, 2) high-risk pregnancies or fetal injuries (due to violence while pregnant), 3) strangulation, 4) healthcare access, 5) reproductive and sexual coercion, and 5) medication.

Advocates can lead into the Health Checklist with a framing statement, such as:

"I've noticed you marked a few things that could lead to some serious health issues. This is common and something we've found is important to talk over. As we go through this tool together, I'd also like to ask you some questions about if or how your health might be affected, and if you'd like to discuss any health needs."

There is a section for advocates/navigators to check-off "yes" answers to the health probes, as well as write any notes based on the discussion that takes place.

Finally, there is a concluding statement that advocates can use to initiate safety planning for any health issues, provide links to onsite health services, provide educational material, and continue discussion with the survivor about their health, wellness, and safety.

This is important as some FJCs emphasize that health is a priority, when asked, for survivors visiting their Center, while others acknowledge that staging health needs later is important. In both situations, retaining survivors in ongoing services is key.

The Checklist is also available in Appendix E(ii).

Spotlight: Van Nuys FJC Pilot Work

The Van Nuys Family Justice Center in North Los Angeles, California served as a pilot site for the Health Checklist. During the testing period, the counselors who completed Danger Assessments and safety planning with survivors found that

82% had experienced some type of reproductive coercion.

These findings have since been put to use to apply for Grants and reconfigure the way their forensic program trains advocates and provides healthcare, to meet these needs.

DANGER ASSESSMENT HEALTH CHECKLIST

(Add to Danger Assessment Scoring Guide)

Danger Assessment Health Checklist: Health Concerns & Safety Planning		
If client answered "YES" to items: # 1, 5, 6, 9, 10, 13, 15	Check if completed	Notes
1) **Probe** about potential medical effects: ***" I've noticed you marked a few things that could lead to some serious health issues. This is common and not your fault. As we go through this tool together, I'd also like to ask you some questions about if/how your health might be affected."*** **Be sure to address overall risk-level. But use the probes below to address other outlying issues and to help you in safety planning.** If client answered "YES" to questions 1, 5, or 9. a. Did you experience any physical health issues or injury as a result? b. Did you receive medical care after the event? Did you need to? c. Has a doctor ever asked you about domestic violence? d. Has a doctor ever diagnosed you with a medical issue?		
If client answered "YES" to questions 9 or 15. e. Have you ever been pregnant? f. Are you concerned that you might be pregnant? g. Have you had any issues with a pregnancy, or other sexual health concerns (such as an STI) as a result of the violence/assault?		
If client answered "YES" to question 10. h. Complete Strangulation Assessment		
If client answered "YES" to question 13. i. Has he ever prevented you from seeking medical care? j. Has a doctor ever asked you about domestic violence?		
If client answered "YES" to question 15. k. Has he ever tampered with your birth control, either trying to prevent you from getting pregnant or coercing you to get pregnant?		
If client answered "YES" to question 20. l. Have you ever been prescribed medication for a mental health concern? m. Are you currently taking it/have it with you?		
2) Refer Sample script: ***" We've talked about a few things today related to your health [summarize some concerns]. While you're here today would you like to talk with someone about any health concerns or make an appointment?"***		
3) Offer Resources Provide information and resources on health and DV. • Futures Health cards, Local resources, Talk with onsite health provider		

Providing On-Site Health Services

When thinking about what onsite services to provide, it's important to think about a full scope of possible services:

- ✓ **Access**
- ✓ **Linkage to Care**
- ✓ **Health Promotion**
- ✓ **Onsite Medical Care**

An onsite medical/health partner is the gold-standard for FJCs, however the prep work of identifying survivor needs and community resources should guide what health services make the best fit for survivors within the FJC.

Access refers primarily to making sure FJC navigators/intake specialists, volunteers, and/or partner agency staff are certified to help survivors enroll in health insurance through the new Affordable Care Act health insurance exchanges or state Medicaid options. Many states have released community outreach grants to organizations to help conduct outreach and enroll underserved populations. General advocacy, including safety planning, should also strive to support a survivor's ability to seek healthcare and maintain/improve their health status.

Linkage to Care should be facilitated and is best done by either training current navigators/intake specialists to pay particular attention to survivors who request health services or appointing a designated "health navigator" to assist with discussion about health, linkages, and follow-up. This is described in more detail on pages 37-38.

Health Promotion activities can be integrated by nearly every partner agency within their current programs. For example, a shelter-based domestic violence program can conduct nutrition classes, hold immunization clinics, discuss health parenting, etc at the shelter. Furthermore, each partner agency at an FJC can make a commitment as to how they can integrate and institutionalize health and wellness in their programs and agency. Bringing in health promotion programming from off-site partner agencies, such as immunization clinics, is also good way of establishing a relationship with a future onsite partner.

Onsite Medical Care can be provided in partnership with a local health department, community health center, or community hospital. They can provide valuable cross-training for advocates and other non-medical staff and partners, participate in joint safety planning with survivors, and provide actual healthcare services for survivors and their children

Spotlight: FJC Sonoma County Virtual Navigator

The Family Justice Center of Sonoma County in California (FJCSC) is piloting a video conferencing system in partnership with a local Federally Qualified Health Center (FQHC) that will act as virtual satellite sites of the FJCSC, providing patients screened for IPV the opportunity to connect with an advocate for risk assessment, safety planning, and connect to FJCSC services. This pilot program was funded by Blue Shield of California to support the major advocacy partner agency, the YWCA, who will provide the advocates to conduct the virtual intake. Further, the YWCA, FJCSC, and FQHC will work together to develop protocols and trainings for FQHC personnel working with domestic violence victims, create secure spaces at the FQHCs where the virtual meeting can take place, and purchase telecommunications equipment.

Program Spotlight: Tulsa Family Safety Center Physician Clinic Program

Physician Clinic Program

Through a partnership with a local teaching medical school, FSC will host Internal Medical Residents to provide health assessments and clinical referrals for survivors, and ultimately provide better healthcare access for survivors. The partnership was developed by the current onsite Clinic Director for Forensic Nursing with the Director of Internal Medicine at the University of Oklahoma College Of Community Medicine. The FSC Director, Suzann Stewart and Operations Manager, Darcy Melendez, worked to develop a simple yet integrated onsite clinic program. The Forensic Nurse Examiner Assessment described above, currently in operation, helped the team build capacity and design a more robust onsite medical services program. Furthermore, the physicians rotating through FSC have an opportunity to learn from curriculum that has been implemented to develop skills in diagnosing and treating patients that have experienced violence, a patient population that is generally underserved and has chronic and complex health needs. Physicians will also gain experience working with professionals and advocates from other disciplines.

Tulsa Program Leaders Prepare Family Safety Center Exam Room for February 12 Physician Clinic Start

Pictured from left to right are Kathy Bell, MS RN and Forensic Nursing Program Director, Tulsa Police Department; Suzann Stewart, Executive Director, Family Safety Center; and, Dr. Martina Jelley, MD, MSPH, FACP Interim Director, Department of Internal Medicine, University of Oklahoma School of Community Medicine

Initial Program Details:

Upper level Internal Medicine residents assigned to their ambulatory block rotation will staff a clinic for patients age 14 and older, one-half day per week in the afternoon. These physicians will have supervision from a faculty attending physician who will be available onsite for at least part of the session, and/or by phone for the whole session. Resident physicians will see patients for any acute or chronic problem. Physicians will take a medical history, perform a physical exam, including a pelvic exam if needed and prescribe treatment, including prescription medications (no controlled drugs). If the physician determines that the patient needs more care than is immediately available at the FSC clinic, arrangements will be made for the patient to be sent to another appropriate facility. The same resident will attend the clinic each week for 4-weeks. Residents will be trained in the functions of the FSC and caring for victims of violence/abuse prior to starting the clinics. Physicians will work with nursing staff to connect patients to a regular source of care. Nursing support will be provided for rooming patients, vital signs, chart maintenance, phone calls, procedures, patient education and help with accessing community resources. Procedures that will be available include: Blood pressure, fingerstick glucose, dipstick urinalysis, small abscess incision and drainage, ear irrigation, trigger point injections and joint injections.

"The purpose of the Physician Clinic Program is to help establish a medical connection for survivors of violence. It is not only expected that survivors utilize immediate medical services at FSC but will be linked to a permanent medical home in the community. The mission of the program is to have every survivor understand that their whole person, including their health, is important and will be cared for. Services provided at the Family Safety Center are trauma-informed, and the clinic will help survivors successfully engage with the larger system of medical care that is often seen as large, scary and insensitive."

– Kathy Bell, FSC Physician Clinic Program Director and TPD Director of Forensic Nursing

Models of Service in Family Justice Centers

When looking to establish new partnerships to address needed health services and programs, **access, linkage, health promotion, and onsite services** should all be considered by those with the authority to develop and implement such changes.

Who provides these services and what they look like should be based on community and survivor needs. Some promising practices and a spectrum of possible health partners are detailed below:

ON-SITE			
MODEL	**BENEFITS**	**CHALLENGES**	**EVIDENCE**
HEALTH PARTNERSHIPS (E.G. COMMUNITY HEALTH CLINICS, RESIDENCY PROGRAMS)	+Build link to personal physician +Cross-training opportunities +Extra use of forensic medical units +Can link to ongoing advocacy/casework +Sustainable funding (CHC partner can bill services) +Potential for multiple partners, based on community resources (e.g. health provider from CHCs, residency programs, private practice, etc)	- Undocumented immigrants do not qualify for coverage - Building relationship with overburdened CHCs or Medical Schools - Need to guarantee patient flow	• CHCs provide primary care to >9 million disadvantaged Americans (Stargield & Shi, 2004). • Patient-centered medical home model has a team/coordination emphasis in line with FJCs (Health Affairs, 2010). • Having a Primary Care Provider (PCP) is the only factor related to receiving regular healthcare (Stargield & Shi, 2004).
HEALTH NAVIGATORS	+FJCs have navigators/caseworkers that can be trained +Cross-training opportunities between +Hospital/clinic and FJC navigator programs +Can link to ongoing advocacy/casework +Health insurance enrollment	- Still need to make referral and link to health care site - Building relationships with health partners - No direct medical/health services on-site	• Nurse Coordinators/Navigators have decreased readmission rates, improved patient adherence, and strengthened patient-provider relations in hospital settings (Health Affairs, 2013). • Pilot studies have shown that advocates (“IPV interventionists”) increased screening and disclosure rates in clinics (Rhodes et al., 2013)
FORENSIC MEDICAL UNITS	+Medical professionals already trained/sensitive to issues of violence +Can link to ongoing advocacy/casework +Many FJCs and/or community clinics have forensic units available	- SART/SANE nurses not necessarily connected to broader health system - Need to train and engage advocates in health issues - Need to engage nurses in ongoing advocacy - Only reimbursed for SA, not DV - Not all are capable of evaluating children	• Documenting DV in medical health records may assist in DV cases (Isaac & Enos, 2001). • Training for providers on trauma and forensics remains limited (Barefoot & Galvan, 2003). • Forensic units and documentation for DV (similar to SA) is expanding in Coalition/Hospital partnerships (MNADV, 2012). • New York State (Bill S1593-2013) passed laws to expand use of forensic medical units.

SEXUAL ASSAULT RESPONSE TEAM (SART) EXPANSION	+Builds on collaborative model of SARTs and FJCs +Creates opportunities for case-review, cross-training, and collaboration building +Can utilize intake specialists at FJCs to coordinate SART (both case management and team meeting coordination) +Provides trauma-informed care	- SANE nurse must be hired/trained by hospital/clinic if not already available - Conflict due to different organizational goals of partners. - Intake specialists need experience or training. - A Coordinator or technical assistance may be necessary to manage the program.	• SART programs have improved relationships among participating stakeholders, increased victim participation in legal proceedings, improved quality of legal evidence, improved legal outcomes, and decreased re-traumatization among victims (Greeson & Campbell, 2012). • Technical assistance is important in bridging any organizational gaps (Greeson & Campbell, 2012). • The National Institute of Justice released a study report demonstrating that SARTs with high levels of formalization, within and across sector collaboration, and that participated in program evaluation were most successful (Campbell et al., 2013). • Components of leadership, stakeholder relationships, and collaborative structure are key concepts in collaborative DV organizations and teams (Nowell, 2009; Campbell et al., 2013)
OFF-SITE			
MODEL	**BENEFITS**	**CHALLENGES**	**EVIDENCE**
MOBILE HEALTH CLINIC	+Broader reach/service area +Builds link to personal physicians +Cost-effective health service alternative	- Need to create link/bridge to advocacy. - Procuring and maintaining mobile unit.	• Effectively addressed asthma and other health disparities among school-aged children. • An effective alternative model of school-based health centers (Bollinger, Morphew & Mullins, 2010). • Has shown 36:1 return on investment in reducing ER visits ($3million) (Oriol et al., 2009). • The combination of outreach and hot-spotting (indentifying areas of specific need) have been used to address emergency room users, Medicaid-paid births (Hardt et al., 2013), and high-concentration areas of violence (OCDV, 2012).
HOME VISITATION PROGRAM	+Already a component of child protection services and public health nursing projects. +Intensive one-on-one assistance in all social and health needs +Potential links to long-term health services (link to healthcare, insurance enrollment, etc.) +Collaborative grants between evidence based programs and FJCs are available.	- Child protective programs have a focus on child/family – mother's needs are secondary - Need strong partnerships for referral for mothers - Issues of mandated-medical reporting and nurse/caseworker comfort in identifying, assessing, and discussing IPV - Difficult to maintain/expand large caseloads (individualized approach)	• Nurse Family Partnership (an evidence based public health nursing model for new mothers) showed improved outcomes for reproductive health concerns, addressed risks of increased violence, and improved nurse/victim relations in a pilot study with an emphasis on IPV screening and care (Jack et al., 2012). • -Addressing IPV is still a sensitive issue with home-visitor programs – there is potential to reduce likelihood for disclosure (especially in child welfare programs) (Davidov et al., 2012)

WARM REFERRALS (Establish a Medical Home)	+Partnership building +Opportunities to link advocacy and practice trauma-informed care +Established via MOU (i.e. easily sustainable)	- Potential for re-traumatization - Need established protocols for treating the referral - May be difficult to establish with already overburdened, service-oriented, Community Health Centers	• WHO Clinical Guidelines (2013) recommend warm referrals as a standard practice of "woman-centered care". • Theories of Stakeholder engagement emphasize involving a variety of stakeholders, and identify their role and value early on in program development. • Warm referrals have been used for a variety of low-enrollment programs within healthcare (Richter et al., 2012).
MOBILE TECHNOLOGY HEALTH PLATFORMS	+Provides options for +Centers with limited health resources +Compatible with the +ACA's emphasis on expanding health information technology, including electronic health records, health portals, etc.	- Expensive technology - Privacy and confidentiality concerns - Mandated medical reporting - May need an in-person follow-up to handle linkage to advocacy after disclosure, or link to long-term care after initial screening.	• Promising practice – little outcome evaluation evidence to date. • Computer-based IPV screening increased rates of disclosure and improved consistency of screening in one pilot study (Post et al., 2013). • Provider follow-up after disclosure was most helpful in making successful links to care (Post et al., 2013). • The ACA is supporting the expansion of electronic medical records (EMRs) and health information technology (HIT, such as patient portals).

Health Navigation

To further help FJCs as they begin to integrate health advocacy and formal onsite healthcare partners into their procedures, the Alliance developed an additional ***Safety Planning for Health Checklist.*** This is for internal use only, as a reminder for advocates to follow-up with survivors on health needs. During pilot site work, it became evident that timing is important when considering survivor priorities. While a survivor may reveal some gaps in healthcare, it may not be a priority in their current situation, compared to other needs, or may not be urgent. In this case, once other needs, such as civil legal assistance, obtaining shelter, or police action are in place, it is important that advocates use health as an opportunity for empowerment. A survivor may be more ready and able to address their or their children's health needs at a later date. Engaging them in continuous dialogue through case management is key. On the other hand, some people will have health needs that are both priorities and urgent, and advocates need pathways to connect survivors to healthcare, whether through 911, an onsite forensic or medical partner, or a trusted offsite healthcare referral.

The following ***Safety Planning for Health Checklist*** is a useful tool for advocates/navigators as they develop skills and comfort including health within advocacy and service navigation work. Find it in the **Appendix E(iii)**.

Upon leaving the FJC after services, whether it was the first visit or a follow up appointment, the ***Safety Planning for Health Checklist*** should be revisited. Advocates should reiterate services and partner agencies that are available at the FJC to survivors, based on their relevancy to survivor needs.

Similar Approaches:

- Clinical supervisors review how/if health was discussed during debriefing meetings with counselors and advocates.
- Include opportunities for feedback on Exit/Satisfaction Surveys
- Use current data collection tools to include tracking of health linkages or other program goals

SAFETY PLANNING FOR HEALTH CHECKLIST

(for Counselor/Advocate to complete after safety planning and during follow-up or case management)

Counselor/advocate should:

- Follow-up on any health needs when making other service referrals or follow-up appointments.
- Explain that staying healthy is an important part of staying safe.
- Provide resources and on- or off-site referrals as necessary.

Safety Planning For Health Checklist

Check all items you conducted with the client during your visit.

Date: _____

☐ This is a follow-up visit ☐ This is an initial visit

Safety Planning:

☐ Oral Follow-up on any health concerns noted during intake, Danger Assessment, or other.
☐ Provided resources or information
☐ Made referral to (health partner/resource) _____.
☐ Summary of safety planning for health (e.g. obtaining medications, appointments to schedule, gathering children's immunization records along with other documentation in case of emergency exit, numbers of providers, etc.).
Please summarize here:

Follow-up appointments:

☐ Client requested health/medical services on (date)_____
☐ Referred to (health partner agency)_____
☐ Client sought health service (called, made appointment, went to health center).
☐ Client received health service.
☐ Client satisfied with health services received.
☐ Additional needs (follow-up appointment, new/changed health concerns).
Explain:

Referred to:

☐ [On-site health provider]
☐ [Off-site health provider]
☐ Insurance Enrollment specialist
☐ Other:_____

Other Comments:

Program Spotlight: Essex County FJC Health Navigator

In 2013, Essex County Family Justice Center was awarded funding by The Nicholson Foundation to serve the medical and behavioral health needs of survivors. A dedicated position was established to implement the following activities:

1. **identify and adopt validated behavioral health screening** and assessment instruments (including psychological trauma, as well as drug and alcohol use),
2. **conduct assessments** for clients identified by the screening instrument,
3. **based upon a readiness to change model, provide guidance and referrals** for needed medical and behavioral health services,
4. **make follow-up calls and schedule follow-up visits** to ensure that clients are receiving needed medical and behavioral health services,
5. **conduct outreach to local medical and behavioral health providers** to establish cooperative service agreements, and
6. **identify or adapt basic screening questions** to determine whether clients are receiving and have access to medical care, including a question about medical insurance, with follow-up as needed, including but not limited to arranging for enrollment in health and behavioral health related entitlement programs.

Screening Tools

The FJC selected two validated medical and behavioral health assessments to help guide initial needs among survivors. The instruments are the CAIG-AID – a widely used and validated alcohol and drug screen and the PCL-S – an abbreviated PTSD Checklist for Civilians and widely used and validated instrument to assess trauma and stress related disorders. With the guidance of the Alliance and local experts, these tools have been incorporated into the comprehensive intake forms of FJC partner agency staff. Based on the answers, survivors are routed to the Medical/Behavioral Health Specialist.

From January 2014 – November 2014:

174 Family Justice Center survivors have been assessed for medical/behavioral health service and linked to providers in the community.
An additional 206 follow up sessions have been conducted to confirm that linkages with needed services were successful and helpful.

Role of the Medical/Behavioral Health Specialist

Linkages to medical or behavioral health providers with whom MOUs have been established are made to address clients' needs as appropriate. For example, if a client is uninsured, the Specialist will assess the client's eligibility for coverage and assist them with the application process. If a client is not receiving routine medical care, the Specialist will encourage the client to seek preventive care and will link the client to a provider. With respect to behavioral health needs, clients with less severe behavioral health needs will be referred to the Center's onsite clinical partners. For more complex needs, the client will be referred offsite for psychiatric services. Urgent or serious behavioral medical needs are immediately sent to offsite partners. The Specialist follows up with clients during and/or after receipt of medical and behavioral health services to learn the outcome of the referral process and to work with the client around next steps.

Increased Partnerships:

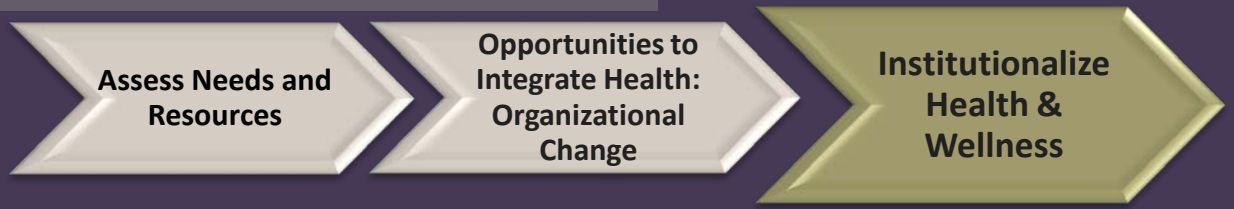
To date, cooperative service agreements have been established with the following medical and behavioral health providers: Bessie Mae Women's and Family Health Center; Integrity House, North Jersey Community Research Initiative and the City of Newark Department of Health and Community Wellness.

PART THREE

Institutionalizing Health and Wellness: Building Partnerships and Integrating Wellness

The most important thing FJCs can do to support the overall health and well-being of their community is to be survivor-driven. According to the Alliance's Guiding Principles, this means "Shaping services to clients by asking them what they need"; let them drive your services.

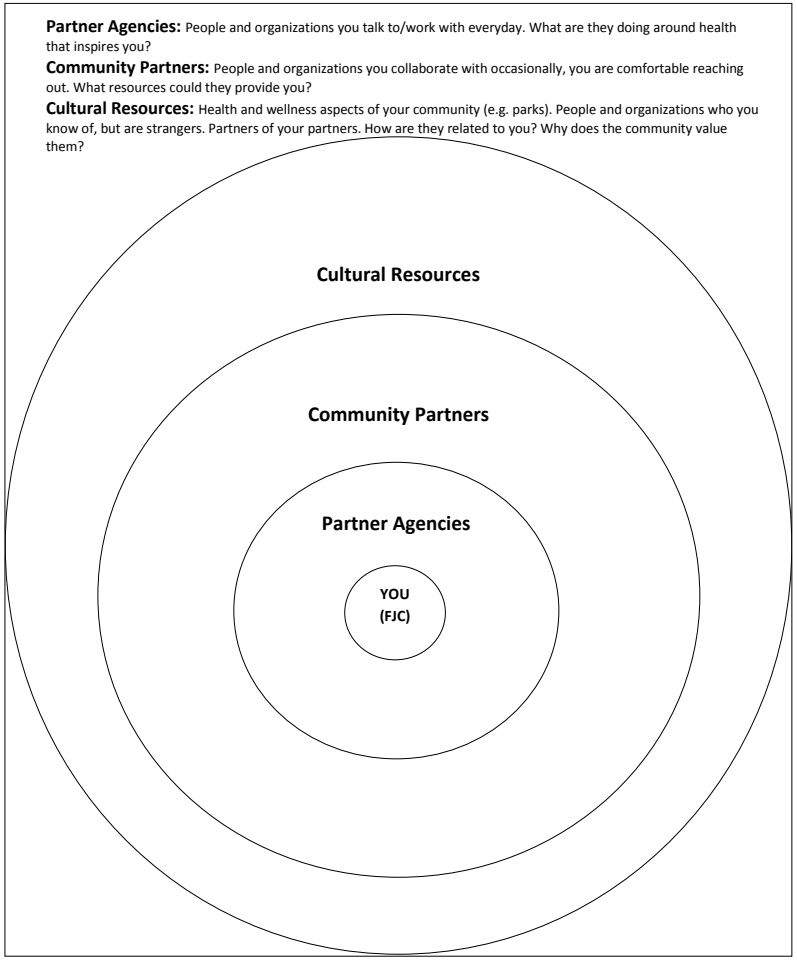
This section focuses on promising practices for institutionalizing a "wellness" framework into FJC operations, beginning with key strategies and steps to building partnerships and ending with the vital and on-going internal work of institutionalizing wellness whether a FJC, collaboration, or single agency.



Institutionalizing Health and Wellness

Building Partnerships with the Health Sector

Various health needs can be met through a variety of sources. Talk to partner agencies about who they refer to most, research major hospital organizations in the community or region, talk to local health departments and/or health and human services about various departments and programs, and brainstorm any alternative providers. The following ***Resource Mapping Chart*** may be helpful to identify partners from the obvious and highly-utilized, to the unknown. The full worksheet is available in **Appendix G**.

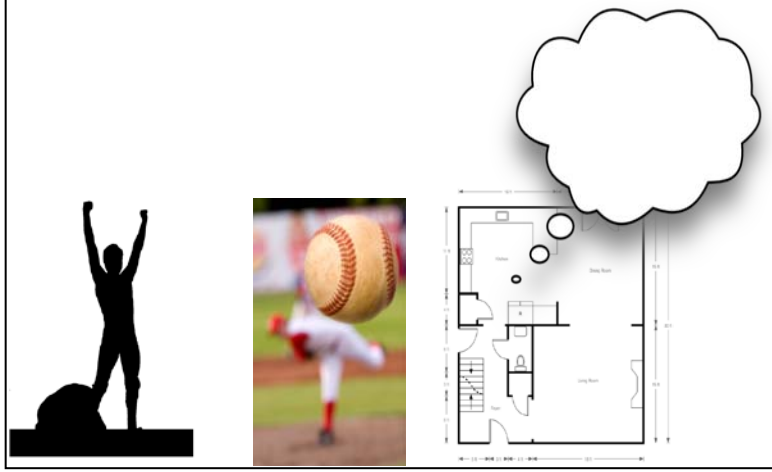


Identify your Medical Champions:

- Who do you know?
- Who do you talk to regularly?
- Who provides for the "wellness" in your community?
- Who is a non-traditional secret weapon?
- Who is a stranger, but you have heard about doing good work in health?

Develop your Pitch:

- State your clients' health needs.
- Note the link between violence and long-term health consequences.
- What resources do you already have to address health?
- What's your dream health initiative?
- How does the plan help address community-wide health priorities?



Potential Partners and Culturally Specific Resources

Here is a brief list of agencies and organizations that can provide much needed services to survivors in your community. Centers may in fact already be partnering with an organization for social services that also provides health services:

- ✓ **Major hospital franchises such as Kaiser Permanente**
- ✓ **Community Health Centers (CHCs), or Federally Qualified Community Health Centers (FQHC)**
- ✓ **Department of Health, City or County Health**
- ✓ **Health and Human Services, Health and Family Services, Child and Family Services**
- ✓ **Local Dental Providers**
- ✓ **Local Vision Providers (Optometry, Ophthalmology)**
- ✓ **School District: School Health, School Health Centers**
- ✓ **Residency Programs: Nursing, Medical (physician), Dental, Vision, Physical Therapy**
- ✓ **Nurse Family Partnership: National organization of public health nurses. Many services or programs are located within City/County Departments**
- ✓ **Veteran Affairs**

Finding New Partners

Although Forensic Programs at FJCs may need to remain dedicated to treating acute Intimate Partner and Sexual Violence, forensic nurses are an important resource. They are medical professionals skilled at working with victim populations in a whole health approach and often are either connected to more comprehensive medical institutions or bring personal and professional relationships to the table that may be able to provide onsite services. Forensic nurses and forensic program directors can also play an important role in designing a comprehensive medical program and determining policies and procedures for how a medical partnership can be integrated within the FJC.

- ✓ **Planned Parenthood: national reproductive health care provider**
- ✓ **Culturally Specific Populations: reach out to local, regional, or state organizations dedicated to particular populations that often identify "preferred-providers"; Recipients of Community Transformation Grants (under the ACA)**
- ✓ **Tribal partners: Indian Health Services is a federal program for native American and native Alaskans that identifies state and local healthcare providers**
- ✓ **LGBTQ: Gay and Lesbian Medical Association, reach out to local LGBTQ organization who often identify and disseminate LGBT-friendly providers to the community**

Making Your Pitch

After assessing the health needs, FJC capacity, and doing some program planning with on and off-site partners, you will be equipped with ample data to approach potential health and medical partners. The healthcare system is needs-based outcomes-focused, and efficiency-driven (i.e. cost-effective) therefore any partnership proposal should clearly state:

- ✓ **Population served:** IPV victims represent an underserved population that can be better targeted by providing services at the FJC. The Affordable Care Act's Women's Health Provision, which emphasizes preventive health and screening for abuse, is good policy to cite when making the link between abuse and health.
- ✓ **Health needs, or gaps in healthcare:** As mentioned in the overview, physical health (due to injury, untreated injury, chronic minor injuries, suppressed immune system due to stress, etc.), chronic disease, and reproductive and sexual health are primary consequences of violence that is cited within academic literature as well as the Alliance's national health survey.
- ✓ **Potential impact:** Discuss the ways in which a partnership with the FJC can reach more patients and serve the mission of the medical/health organization. Some important buzzwords to use for this can include: cross-training, increased access to care, whole person care, innovative healthcare delivery, decrease high-frequency ED users, increase patient retention in disease management, improve medical adherence, etc.
- ✓ **Partnership models:** As provided in the table above, have ready various partnership ideas that can meet the needs of survivors across a spectrum of care (from health promotion programming to on-site medical care). Frame your needs carefully: healthcare providers are required to conduct community health needs assessments, where priorities and goals are commonly stated. Learn how to angle your proposal to fit within their scope of services and community priorities. At the same time, you are equipped to help establish new priorities related to serving this population.

Institutionalizing Wellness: Program Development and Staff Wellness

The Parallel Process: Staff Wellness Programs

In order for an FJC to successfully consider and expand the health services for survivors, a parallel process of internal organizational work that supports and strengthens the health and wellness of staff and partners is key. This is the making of a "culture of wellness".

Demonstrating that client health and wellness is a priority area for direct services begs the question: "How does this FJC prioritize the health and wellness of staff and partners?" It's likely that existing resources already exist within the organization, and can be leveraged to emphasize wellness amongst your team. In fact, if resources are available – whether re-existing or found from external funding or sources – it is an ideal time to expand self-care opportunities and health-promotion efforts. This will facilitate all stakeholders recognizing that health is a priority issue for the entirety of the organization, and ultimately support the organizational integrity of expanding health services. While a comprehensive guide to establishing employee wellness programming is beyond the scope of this particular toolkit, there are many impressive, comprehensive resources available online. Meanwhile, to fuel the spark, here are a few creative approaches worthy of consideration.

- **Utilize current benefits:** Employee Assistance Program may have a wide array of ready-made resources available, including tip sheets and gym discounts.
- **Use your assets:** Local fitness and yoga establishments are often willing to offer low-cost or free classes to employees and volunteers as a way of giving back to the community.
- **Start small:** A monthly employee wellness newsletter paired with a quarterly employee health-promoting activity can be enough to get started.
    - **Change incentives:** A bowl of fresh fruit in the employee break area, ideally replenished every week, is another low-barrier method to supporting the health of team.
    - **Be purposeful:** Provide healthier food options at meetings and tell staff why the decision was made. Gives teeth to wellness messaging!
    - **Be mindful:** Launching existing staff meetings with a recorded mindfulness meditation sets a tone of wellness and reconfirms health as an organizational priority.
    - **Build the team:** Creating a team to participate in a local 5k/ walk/run (or similar) event promotes health while also building staff cohesion.
    - **Build capacity:** University public health programs are often looking for field placement sites for interns. Public health promotion or public health education students arrive with many of the skills necessary to support employee wellness program development and/or evaluation projects.
- **Appoint a health champion:** It is highly recommended that the staff person facilitating employee health and wellness is the champion and cheerleader of the efforts. Passion is a plus!

The nature of the work done within the FJC increases the likelihood that employee wellness plans will be “back-burnered” in response to emergent issues. While that may seem wise and necessary in the short-term, the long-term impact is to undermine the integrity of client-focused health services. For an FJC to fully integrate an organizational shift to value client health, employee health must be seen as equally important. Remember, the focus on employee health and wellness must be sustainable, so create a plan that is doable given organizational resources. And have fun!

Build Foundations of Change: Program Development

Thinking about health services in tandem with organizational health will likely fuel the fires of innovation, inspire staff to take on new initiative, build capacity, and help establish new connections. The practice of engaging with staff on a level of health and wellness can support a deeper understanding of organizational strengths to help identify and institutionalize wellness activities.

Share Findings

Share the findings of assessment, partnership building, and lessons learned form services with FJC staff and partners! Reports, community forums, staff or team meetings, fact sheets, etc. all provide excellent venues to document successes and lessons learned with staff, partners, survivors, funders, and the community at large.

For an FJC to fully integrate an organizational shift to value client health, employee health must be seen as equally important.

Challenge Collaborating Partners

Once they have heard what survivors want in terms of health services as well as what “health” and “wellness” ***mean*** to survivors, ask each person and agency “What can you do to better serve a vision of health?” Legal services and shelter or housing programs, for example, should be able to find ways to reinvent how they approach their work from the framework of wellness. This may be anything from simply asking about health, reframing intake forms or other documents to be more trauma informed, to conducting trainings and doing deep organizational changes to better support needs.

What can partners do to better serve a vision of health?

Engage Survivors

Utilize your VOICES Committee or other empowerment groups to deliver messages about new services, to be on planning committees, to help train potential medical and health partners, and to review and evaluate services related to health. Survivors should be fully engaged in all processes.

Monitor Practices: Staff Roles

Appoint a “Health Coordinator” in your FJC. This can be a paid, full-time position, or a volunteer or partner agency staff member that is given the role (and granted the necessary authority) to approach the FJC’s work, programs, partners, and practices from a health and wellness perspective. Make it this person’s role to evaluate policies, procedures, and practices with an eye for wellness. Give them the authority to challenge partners with the questions: “Is this [program,/practice/service) taking into account the health needs of survivors?” “Does this work to support the overall wellness of people

who come into the FJC?" "How can this program/practice/service be enhanced to consider health and wellness?" And, importantly, "How can we formalize this wellness work so that it is sustained?"

Evaluation: Transparency and Innovation

Build evaluation into programs for staff wellness and health services for survivors. The assessment process should help the planning team identify the intended impacts of the work, evaluation creates a process for understanding what changes actually occurred and how. Evaluation provides data and narratives well suited for funders, helps create buy-in with new partners or funders, builds a process for transparency, reflection, and feedback (only if shared!), and sets a framework for future growth.

To maximize the impact of the employee wellness program, it's highly recommended to build in evaluation methods from the beginning. Confirming the preferences of staff before launch via brief focus groups or a survey will allow efforts to align with staff interests. Prior to launching activities, establishing baseline self-reported wellness scores can be accomplished by administering the widely available Professional Quality of Life (ProQOL) self-assessment.

Planned periodic re-administration of the ProQOL allows for monitoring the impact of employee wellness strategies. Program plans should be modified in response to evaluation findings.

Mentioned previously, schools of public health are eager to find field placements for public health graduate students who can assist in the process from needs assessment, program development, to designing and implementing evaluation.

Kim Goldberg-Roth, Executive Director, and Kathy Adams, Former Clinical Director of the SART team; Strength United and Van Nuys Family Justice Center

Spotlight: Strength United's Investment in Organizational Wellness

Sheri Strahl, MPH, authored and contributed extensively to this section on institutionalization. Sheri joined Strength United in 2014, bringing both administrative expertise and a deep investment in health and wellness to the work and culture of Strength United. Recognizing the need to ameliorate the impact of sexual and domestic violence responders' repeated exposure to trauma, Sheri began planning and implementing low-barrier wellness-promoting strategies for staff. Focus groups and anonymous web-based surveys ensured that wellness activities aligned with staff preferences. Sheri also applied lessons learned via trainings conducted by industry leaders including Francoise Mathieu and Laura van Dernoot Lipsky, whose books are widely available. Positive post-activity responses from staff drive continued efforts, and the use of health-promotion volunteers renders the staff wellness program both viable and sustainable.

Conclusion

Remember, health and wellness fit within the framework of trauma-informed care and safety for survivors. It can be easy to provide a new service that might address a medical concern of a survivor, but that may, in turn, neglect their overall sense of safety and wellness. Health services should be part of the whole person you are interacting with at the FJC. Just as there are many strategies for ensuring physical safety, there are many avenues to improving the physical or medical health of survivors. A doctor may be in order; alternatively, child care so that a mother has time to schedule appointments or simply rest may create the pathway for improved health. It is the mission of every FJC to be the conduit of integrated services that are shaped to meet the whole needs, adapt to changing needs, and strategize action plans for every survivor.

Health partners matter, and are vital to serving complex and varying needs. The empowerment and hope that health can bring, however, is what heals.

Health Matters. Hope Heals.

Appendices

A. Works Cited & Resources
B. Alliance Health Survey: English and Spanish
C. Health and Wellness Focus Group Supplement
D. Health Services Survey
E. Alliance Health Toolkit:
    i. Health Assessment Questions
    ii. Danger Assessment Health Checklist
    iii. Safety Planning for Health Checklist
F. Family Safety Center – Forensic Nurse Checklist
G. Resource Mapping Worksheet
H. Health Services Planning Guide

Appendix A: Works Cited & Resources

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Appendix B: Alliance Health Survey (English & Spanish)

Family Justice Center Alliance

Health Needs Survey

Date: _____

This is a survey to help the Family Justice Center Alliance understand more about the health needs of our clients.
The survey is completely voluntary and confidential.

You do not have to answer any question that makes you feel uncomfortable.

Demographics

Age	Gender	Ethnicity	Primary Language	Employment Status	Education
_____ *years*	☐ Female ☐ Male ☐ Transgender ☐ Other	☐ American Indian / Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latina ☐ Native Hawaiian / Pacific Islander ☐ White ☐ Multiracial ☐ Other:_____	☐ Arabic ☐ ASL ☐ Cambodian ☐ English ☐ French ☐ Korean ☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese ☐ Other: _____	☐ Not working ☐ Student ☐ Seasonal/temporary ☐ Military ☐ Working part-time ☐ Working full-time	☐ Less than high school ☐ High school diploma/GED ☐ Some college ☐ Completed college ☐ Advanced/professional degree

Do you have children?	Are you pregnant?	Were you born in the United States?	How long have you been coming to this Family Justice Center?
☐ Yes ☐ No **How many currently live with you? _____**	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No	☐ This is my first visit ☐ I come for occasional services ☐ I use on-going services (therapy, etc.)

Insurance Coverage

1. Do you currently have health insurance coverage?

☐ Yes, through my work
☐ Yes, through someone else's work (like a spouse or parent)
☐ Yes, I purchase private insurance
☐ Yes, I have public or state insurance (Medicaid, Medicare)
☐ Yes, I have Indian Health Service coverage
☐ Yes, through the military
☐ No, I do not currently have any insurance

2. **If yes, what does your insurance cover**? *Check all that apply* ☐ Health ☐ Vision ☐ Dental ☐ Don't know / not sure

3. **In general, how would you rate your health?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

4. **Do you have a primary care doctor?** ☐ Yes ☐ No Date of last visit? _____ *(month/year)*

5. Have you experienced or has a doctor told you that you have any of the following *PHYSICAL HEALTH* conditions?

☐ Headaches	☐ Heart disease or heart attack	☐ High Blood Pressure	☐ Physical injury: _____
☐ Fatigue	☐ Thyroid problems	☐ Diabetes	☐ Frequent colds/flues
☐ Constant pain	☐ Liver disease	☐ Asthma	☐ Physical disability
☐ Stomach ulcers	☐ Arthritis	☐ Emphysema	☐ Hearing loss
☐ Head trauma	☐ Cancer: type:_____	☐ Irritable Bowel Syndrome	☐ Other:_____

6. Have you experienced or has a doctor told you that you have any of the following *SEXUAL HEALTH* conditions?

☐ Sexually Transmitted Diseases (e.g. Chlamydia, Gonorrhea)	☐ Vaginal Infections ☐ Pelvic Pain	☐ Urinary Tract Infections (bladder infections)	☐ Other: _____
☐ HIV/AIDS	☐ Painful Intercourse (sex)	☐ Problems with pregnancy	

7. Are any of the above health concerns related to your experience of violence?
☐ Yes ☐ No ☐ Don't know

8. Have you received treatment for any of these health concerns in the <u>past 12 months?</u>
☐ Yes ☐ No ☐ N/A

9. Is anything preventing you from receiving or following up with treatment? *(Check all that apply)*

☐ No, I receive regular care
☐ Too expensive
☐ Transportation is difficult
☐ No insurance / insurance does not cover
☐ Clinic hours, scheduling, or wait times are hard for me
☐ Other _____

10. **Have you gone to the Emergency Room in the <u>last 12 months?</u>** ☐ Yes ☐ No

11. Have you been prescribed medication in the *last 12 months*? □ Yes □ No

12. **If yes, are there any barriers to taking your medication as your doctor instructed?** (*Check all that apply)*

□ Too expensive
□ Transportation (it is difficult to travel to a pharmacy)
□ No insurance / Insurance does not cover
□ I am not sure how I need to take it
□ Other:_____

13. Are you currently using a birth control method (condoms, birth control pills, etc.)?

□ Yes, regularly □ No, but I would like to receive services □ No, not interested □ N/A

Psycho/Social History

14. **In general, how would you rate your mental health?** □ Excellent □ Good □ Fair □ Poor

15. **Have you experienced any of the following *MENTAL HEALTH* symptoms?** *Check all that apply*

□ Anxiety
□ Panic Attacks
□ Anger/Temper
□ Low Self-Esteem
□ Changes in Appetite
□ Hearing Voices
□ Changes in sexual desire
□ Long periods of sadness / depression
□ Difficulty controlling behavior
□ Difficulty controlling emotions
□ Avoiding people or situations
□ Trouble Sleeping (insomnia)
□ Nightmares
□ Flashbacks
□ Other: _____

16. Are any of the above mental health concerns related to your experience of violence?

□ Yes □ No □ Don't know

17. Have you gone to see a mental health professional for these symptoms in the *past 12 months*?

□ Yes □ No □ N/A

18. Is anything preventing you from receiving or following up with MENTAL HEALTH care?

□ No, I receive regular care
□ Too expensive
□ Transportation is difficult
□ No insurance / insurance does not cover
□ Clinic hours, scheduling, or wait times are hard for me
□ Other _____

19. On average, how many *days per week* do you drink alcohol?

□ I do not drink alcohol □ 1 day □ 2 days □ 3 days □ 4 days □ 5 days □ 6 days □ 7 days

20. On a typical drinking day, how many drinks do you have?

□ I do not drink alcohol □ 1 drink/day □ 2 drinks/day □ 3 drinks/day □ 4 drinks/day □ 5+ drinks/day

21. On average, how many *days per week* do you use recreational drugs (marijuana, cocaine, prescription drugs, etc..)?

□ I do not use recreational drugs □ 1 day □ 2 days □ 3 days □ 4 days □ 5 days □ 6 days □ 7 days

22. Do you smoke?

□ No, never □ 1-5 cigarettes ***per week*** □ 1-5 cigarettes ***per day*** □ ½ pack per day □ 1 pack per day □ 1+ pack per day

23. Do you have any difficulty getting around or performing daily tasks due to physical, mental, or emotional health?

□ Yes □ No

24. If yes, do you have someone (family, friend, professional) who helps you with your health needs?

□ Yes □ No

Dental/Vision

25. Do you have any current DENTAL concerns?

□ Cavities
□ Gum sensitivity or bleeding
□ Frequent tooth pain
□ Tooth abscess (root pain and infection)
□ Tooth decay
□ Broken or missing teeth
□ Other: _____

26. **Have you gone to see a DENTIST in the *past 12 months*?** □ Yes □ No

27. **Is anything preventing you from receiving or following up with DENTAL care?** *(Check all that apply)*

□ No, I receive regular care
□ Too expensive
□ Transportation is difficult
□ No insurance / insurance does not cover
□ Clinic hours, scheduling, or wait times are hard for me
□ Other _____

28. Do you have any current VISION / EYE problems?

□ Near sighted / far sighted
□ Astigmatism (blurred vision)
□ Glaucoma
□ Retinal detachment/tearing
□ Sudden loss of vision
□ Partial/full blindness
□ Other:_____

29. **Have you gone to see an EYE DOCTOR in the *past 12 months*?** □ Yes □ No

30. **Is anything preventing you from receiving or following up with VISION / EYE care?** *(Check all that apply)*

□ No, I receive regular care
□ Too expensive
□ Transportation is difficult
□ No insurance / insurance does not cover
□ Clinic hours, scheduling, or wait times are hard for me
□ Other _____

31. Are any of the above DENTAL AND/OR EYE health concerns related to your experience of violence?

□ Yes □ No □ Don't know

Preventative Health

32. Have you received any of the following *HEALTH SCREENINGS OR EXAMS* within the *last 12 months*?

□ Regular dental cleanings/check-ups
□ Regular vision screenings
□ Pap Smear
□ Flu vaccine (shot or nasal spray)
□ Mammogram (breast cancer test)
□ HPV vaccine (cervical cancer or genital warts vaccine)
□ Breast exam (self or provider administered)
□ Blood pressure screening
□ Cholesterol screening
□ Other: _____

33. On average, how many days *per week* do you take part in physical activity or exercise *for at least 30 minutes*?

□ 0, I do not exercise □ 1day □ 2days □ 3days □ 4days □ 5days □ 6days □ 7days □ Don't know / Not sure

34. During the past 30 days, how often did you drink regular soda or pop, or other sugary juices or drinks (do not include diet soda or 100% fruit juice)?

□ More than once a day □ Once a day □ 1-2 times per week □ A few times (less than 5) in the past 30 days

35. Of all the services available at this FJC, what are your MOST IMPORTANT needs?

Check the **TWO** most important:

□ Social services (housing, public assistance, etc)
□ Civil or Legal services (restraining orders, court advocacy, etc)
□ Services for my children
□ Healthcare
□ Counseling or therapy
□ Other: _____

36. What health related services, if any, would you like the Family Justice Center to offer?

□ Vision / eye care
□ Dental care
□ Women's health / reproductive health
□ Primary care
□ Well-baby check-ups
□ Immunizations / vaccines
□ Health insurance enrollment
□ Preventive health screenings (mammograms, etc.)
□ Mental health
□ Substance Abuse Counseling
□ Chronic Disease management (Diabetes, high blood pressure, etc)
□ Nutrition
□ Holistic health (yoga, meditation, etc.)
□ Health Education
□ Other: _____

37. Would you like health information and / or services for your children?

□ Yes □ No □ N/A

38. Any other comments about how the FJC can serve the health needs of survivors?

THANK YOU!
We appreciate your assistance with this survey.

Please return this survey to the DESIGNATED, CONFIDENTIAL AREA.
Questions? Please ask an FJC Staff Member or Advocate.

All information will remain completely confidential.

Family Justice Center Alliance

CUESTIONARIO SOBRE LA SALUD

Fecha: _____

Este es un cuestionario para ayudar a la Alianza de Centros de Justicia para la Familia conocer más acerca las necesidades de salud de nuestros clientes. ***El cuestionario es completamente voluntario y confidencial.***

Usted no tiene que responder cualquier pregunta que le haga sentir incómodo.

Información Demográfica

Edad	Género	Origen étnico	Idioma Principal	Estado de Empleo	Nivel de Educación
_____ *años*	☐ Mujer ☐ Hombre ☐ Transgénero ☐ Otro	☐ Indio Americano / nativo de Alaska ☐ Asiático/ Islas del Pacífico ☐ Afro-americano ☐ Hispano/Latino ☐ Nativo de Hawái / Islas del Pacífico ☐ Blanco ☐ Multirracial ☐ Otro:_____	☐ Árabe ☐ ASL ☐ Camboya ☐ Inglés ☐ Francés ☐ Coreano ☐ Ruso ☐ Español ☐ Tagalog ☐ Vietnamita ☐ Otro:_____	☐ No trabajo ☐ Estudiante ☐ Trabajo Temporal ☐ Militar/Ejercito ☐ Trabajo tiempo parcial (menos de 40 horas) ☐ Trabajo tiempo completo (40 horas o más)	☐ Menos que la secundaria ☐ Diploma de la secundaria / GED ☐ Poca universidad ☐ Graduado de la universidad ☐ Título profesional

¿Tiene niños?	Está embarazada?	¿Nació en los Estados Unidos?	¿Cuánto tiempo ha estado viniendo a este Centro de Justicia para la Familia?
☐ Sí ☐ No **¿Cuántos viven con usted? _____**	☐ Sí ☐ No ☐ No sé	☐ Sí ☐ No	☐ Primera visita ☐ Vengo a veces por servicios ☐ Uso servicios regularmente (consejería, etc.)

Seguro Medico

1. ¿Tiene seguro médico?

☐ Sí, a través de mi trabajo
☐ Sí, a través del trabajo de otro (marido, padres, etc.)
☐ Sí, compro seguro privado
☐ Sí, a través del Estado / gobierno (Medicaid, Medicare)
☐ Sí, a través del Servicio de Salud para los Indios
☐ Sí, a través del ejercito
☐ No, no tengo seguro medico

2. Si tiene seguro, ¿que cubre? *(Marque todas que correspondan)* ☐ Salud ☐ Visión ☐ Dental ☐ No sé

3. En general, ¿cómo calificaría su salud? ☐ Excelente ☐ Buena ☐ Normal ☐ Mala

4. ¿Tiene un médico primario? ☐ Sí ☐ No Ultima visita (fecha)? _____ *(mes/año)*

5. ¿Ha sentido, o tiene un médico que le haya dicho que usted tiene cualquiera de las siguientes CONDICIONES FISICAS?

☐ Dolor de cabeza	☐ Enfermedad cardiovascular	☐ Hipertensión / tensión alta	☐ Heridas físicas: _____
☐ Cansancio/agotamiento	☐ Problemas de tiroides	☐ Diabetes	☐ Resfriados /gripas frecuentes
☐ Dolor constante	☐ Enfermedad hepática	☐ Asma	☐ Discapacidades físicas
☐ Ulceras en el estómago	☐ Artritis	☐ Enfisema	☐ Pérdida de oír
☐ Trauma en la cabeza	☐ Cáncer: tipo:_____	☐ Síndrome de colon irritable	☐ Otro(s):_____

6. ¿Ha sentido, o tiene un médico que le haya dicho que usted tiene cualquiera de las siguientes CONDICIONES SEXUALES?

☐ Enfermedad de transmisión sexual (ej. Clamidia, Gonorrea)	☐ Infección vaginal	☐ Infección urinaria	
☐ VIH/SIDA	☐ Dolor pélvico	☐ Complicaciones de embarazo	☐ Otro(s): _____
	☐ Coito doloroso		

7. ¿Alguno de estos problemas son causados por su abuso?
☐ Sí ☐ No ☐ No sé ☐ Prefiero no decir

8. **¿Ha recibido tratamiento para cualquiera de estos problemas de salud en los <u>últimos 12 meses</u>?**
☐ Sí ☐ No ☐ N/A

9. ¿Algo le impide recibir o seguir con el tratamiento de estos problemas? *(Marque todo que corresponda)*

☐ No, yo recibo tratamiento regular
☐ Muy caro
☐ Transporte es difícil
☐ No tengo seguro / seguro no cubre
☐ Horas de operación de la clínica, o tiempo de espera es muy difícil
☐ Otro(s) _____

10. ¿Ha ido a la sala de emergencia en los <u>últimos 12 meses</u>? □ Sí □ No

11. ¿Le han recetado medicamentos en los <u>últimos 12 meses</u>? □ Sí □ No

12. Si respondió sí ¿existen obstáculos para tomar su medicamentos como su médico le indico?
(Marque todo que corresponda)

□ Muy caro
□ Transporte es difícil
□ No tengo seguro / seguro no cubre
□ No estoy segura como tengo que tomar los medicamentos
□ Otro(s):_____

13. ¿Tiene método de control de natalidad (condones, píldoras de método anticonceptivo, etc.)?
□ Sí, uso un método regular □ No, pero me gustaría servicios □ No, no tengo interés □ N/A

Historia Psicológica

14. En general, ¿cómo calificaría su salud mental? □ Excelente □ Buena □ Normal □ Mala

15. ¿Ha tenido cualquiera de los siguientes síntomas de SALUD MENTAL?

□ Ansiedad
□ Ataque de pánico
□ Mal humor / ira
□ Baja autoestima
□ Cambios de apetito
□ Oír voces
□ Cambios en deseo sexual
□ Largos períodos de tristeza(depresión)
□ Dificultad en controlar comportamientos
□ Dificultad en controlar emociones
□ Evitar el contacto con personas o lugares
□ Insomnio
□ Pesadillas
□ Recuerdos recurrentes
□ Otro(s):_____

16. ¿Alguno de estos problemas son causados por su abuso?
□ Sí □ No □ No sé □ Prefiero no decir

17. ¿Ha ido a ver un profesional de la salud mental (consejero) por estos síntomas en los <u>últimos 12 meses</u>?
□ Sí □ No □ N/A

18. ¿ Algo le impide recibir o seguir con el tratamiento de estos problemas de la SALUD MENTAL?
(Marque todo que corresponda)

□ No, yo recibo tratamiento regular
□ Muy caro
□ Transporte es difícil
□ No tengo seguro / seguro no cubre
□ Horas de operación de la clínica, o tiempo de espera es muy difícil
□ Otro(s) _____

19. En general ¿cuántos días a la semana usted toma bebidas alcohólicas?
□ 0, yo no tomo □ 1 día □ 2 días □ 3 días □ 4 días □ 5 días □ 6 días □ 7 días

20. En un día típico, ¿cuántas bebidas alcohólicas tiene?
□ 0, yo no tomo □ 1 bebidas/día □ 2 bebidas/día □ 3 bebidas/día □ 4 bebidas/día □ 5+ bebidas/día

21. En una semana típica, ¿cuántos días a la semana utiliza drogas (marihuana, cocaína, medicinas recetadas, etc.)?
□ 0, yo no uso drogas □ 1 día □ 2 días □ 3 días □ 4 días □ 5 días □ 6 días □ 7 días

22. ¿Usted fuma?
□ No fumo □ 1-5 cigarrillos por semana □ 1-5 cigarrillos al día □ ½ paquete al día □ 1 paquete al día □ 1+ paquete al día

23. ¿Tiene dificultades con actividades diarias debido a la salud física, mental o emocional?
□ Sí □ No

24. Si respondió sí, ¿tiene alguien (familia, amigo, otra) que le ayuda?
□ Sí □ No

Dental/Visión

25. ¿Ha tenido cualquier problema con su SALUD DENTAL?

□ Caries
□ Sensibilidad o sangriento de las encías
□ Dolor de los dientes
□ Absceso (infección del diente)
□ Falta de dientes o diente partido
□ Otro(s): _____

26. ¿Ha ido a ver un dentista en los <u>últimos 12 meses</u>? □ Sí □ No

27. ¿Algo le impide recibir o seguir con el tratamiento de la SALUD DENTAL? *(Marque todo que corresponda)*

□ No, yo recibo tratamiento regular
□ Muy caro
□ Transporte es difícil
□ No tengo seguro / seguro no cubre
□ Horas de operación de la clínica, o tiempo de espera es my difícil
□ Otro(s) _____

28. ¿Ha tenido cualquier problema de SALUD OCULAR (o de visión)?

☐ Miope / Hipermetropía
☐ Astigmatismo (visión nublado)
☐ Glaucoma
☐ Desprendimiento de la retina
☐ Pérdida súbita de la visión
☐ Ceguera total / parcial
☐ Otro(s):_____

29. ¿Ha ido a ver un oftalmólogo / oculista en los <u>últimos 12 meses?</u> ☐ Sí ☐ No

30. ¿Algo le impide recibir o seguir con el tratamiento de la SALUD OCULAR? *(Marque todo que corresponda)*

☐ No, yo recibo tratamiento regular
☐ Muy caro
☐ Transporte es difícil
☐ No tengo seguro / seguro no cubre
☐ Horas de operación de la clínica, o tiempo de espera es my difícil
☐ Otro(s) _____

31. ¿Alguno de estos problemas de su SALUD DENTAL U OCULAR son causados por su abuso?
☐ Sí ☐ No ☐ No sé ☐ Prefiero no decir

Salud Preventiva

32. ¿Ha recibido los siguientes DIAGNOSITICO / EXAMENES DE SALUD en los <u>últimos 12 meses</u>?

☐ Limpieza de dientes y consultas con un dentista
☐ Diagnósticos y consultas de visión
☐ Papanicolaou / o consultas de salud sexual
☐ Vacuna contra la gripe
☐ Vacuna Contra el Virus de Papiloma Humano (VPH)
☐ Mamografía o mamograma (por medico o autoexamen)
☐ Diagnóstico de presión arterial
☐ Diagnóstico de colesterol
☐ Otro(s):_____

33. En una semana típica, ¿Cuanto días a la semana hace ejercicio físico por <u>lo menos 30 minutos</u>?
☐ 0, yo no hago ejercicio ☐ 1 día ☐ 2 días ☐ 3 días ☐ 4 días ☐ 5 días ☐ 6 días ☐ 7 días ☐ No sé

34. En los últimos 30 días, ¿Con qué frecuencia ha bebido una soda/ gaseosa, jugo azucarado, o otras bebidas azucaradas (no incluyen sodas dietas o jugo de 100% fruta)?
☐ Más de una vez al día ☐ Una vez al día ☐ 1-2 veces al semana ☐ Menos que 5 veces en los últimos 30 días

35. De todos los servicios disponibles en el Centro, ¿cuáles son sus necesidades MÁS IMPORTANTES?
Marque los **DOS (2)** servicios más importantes.

☐ Servicios sociales (asistencia de vivencia, asistencia pública, etc.)
☐ Servicios legales (Orden de restricción, consejo para el corte)
☐ Servicios para los niños
☐ Servicios de la salud
☐ Terapia / consejería
☐ Otro(s): _____

36. ¿Qué servicios de salud, si cualquiera, le gustaría que ofrezca el Centro?

☐ Visión / ocular
☐ Tratamiento dental
☐ Salud para mujeres / salud reproductiva
☐ Atención primaria
☐ "Well-baby" – para infantes
☐ Inmunizaciones / vacunas
☐ Inscribirse en seguro medico
☐ Diagnósticos de salud (mamografías, etc.)
☐ Salud mental
☐ Consejería contra el abuso de sustancias
☐ Manejo de enfermedad crónica (Diabetes, presión alta, etc.)
☐ Nutrición
☐ Salud holística (yoga, meditación, etc.)
☐ Promoción y educación de la salud
☐ Otro(s): _____

37. ¿Quisiera información o servicios de salud para los niños?
☐ Sí ☐ No ☐ N/A

38. Otros comentarios sobre como el Centro puede servir las necesidades de salud para todos que vienen?

¡¡MIL GRACIAS!!
Agradecemos su ayuda en este cuestionario.

Por favor, devuelva el cuestionario al área designada.
<u>Toda su información se mantendrá confidencial.</u>

Appendix C: Health & Wellness Focus Group Supplement

Health and Wellness Focus Group

Draft Supplement to *Alliance Focus Group Toolkit*

September 2014

Focus Group Process and Contents of this Guide:

- **Confidentiality and Consent:** Give each participant a written consent form; Facilitator should explain the purpose, objectives, and confidentiality out loud, then ask participants to sign the form and return.
- **Facilitator Introduction:** Introduce yourself and purpose of the focus group.
- **Participant Guide:** Provide handout of learning objectives and, if available, write overarching questions on chalk/white board or flipchart.
- **Participant Introductions:** Go around the room/table for introductions of all participants, gathering name, date of first service, and any of the provided introduction questions (or one of your own).
- **Script and Questions:** A suggested guide for asking questions, probes, and facilitating the conversation.
- **Facilitator Role:** Describes the function of the facilitator, and tips to managing groups.

Script and Questions

1) What does being "healthy" mean to you?

2) What does "wellness" mean to you? Is it different than "health"?

3) Do you feel that you are healthy? Well?

4) Before coming to the FJC, did you have any health concerns?

5) As much as you feel comfortable, can you describe how you handled your health needs in your relationship?
   Probe: Did the violence impact how you handled your health needs?

6) When you first came to the FJC, were you able to address or talk about any health needs?
   Probe: Was this a priority for you?

7) Do you think it's important for the advocates and other partners here to ask people about health?
   Probe: If so, how would you like people to talk with you about health or wellness when coming in for services related to domestic violence?

8) Is there anything the FJC can do or do better to support your long-term health and wellness?

9) Are there any barriers or issues you have currently that make it difficult to address your health concerns?

10) If health services, like general check-ups, vaccines, cholesterol checks, etc., were offered here at the FJC, would you come for services?

11) Is there anything else you'd like to say about your experience of health and violence?
   Probe: Anything you think FJCs can do to best support the long-term health and wellness of survivors?

Appendix D: Health Services Survey

COUNSELOR HEALTH SERVICES SURVEY

We are interested in expanding health and medical services for victims at Valley CARES Family Justice Center. This survey will help us understand staff needs, develop future programming, and assess client outcomes. We appreciate your participation. Please answer the following questions to the best of your ability.

This survey is completely confidential.

DEMOGRAPHICS

1. How long have you been working at Valley CARES Family Justice Center?
☐ less than 3 months ☐ 3-6 months ☐ 6 months to 1 year ☐ over 1 year

2. What type of training have you received?

☐Domestic violence	☐ Safety Planning
☐Sexual assault	☐ Danger/high-risk Assessment for DV
☐Elder abuse	☐ Health consequences of violence
☐Child abuse	☐Strangulation identification and/or assessment
☐Law enforcement protocols/policies	☐Other:_____

3. Do you have any prior experience working/training in healthcare settings (social work, medicine, nursing, etc.)?	☐Yes, Describe_____ ☐No ☐Not sure
4. About how many clients did you see in the last week?	#_____
5. Of these, how many were follow-up visits (not the first visit)?	#_____

2. HEALTH SERVICES

1. If someone you're speaking with has a health/medical need **WHO** do you refer them to? (list or check "Not sure")	Name/agency_____ ☐ Not sure

2. How often do you discuss the **dental** health needs of victims)?
☐ Almost never ☐ Rarely ☐ Sometimes ☐ Regularly/often

3. How often do you discuss the **vision** health needs of victims?
☐ Almost never ☐ Rarely ☐ Sometimes ☐ Regularly/often

4. How often do you discuss the **physical (non-acute)** health needs of victims?
☐ Almost never ☐ Rarely ☐ Sometimes ☐ Regularly/often

5. How often do you discuss the **mental** health needs of victims?
☐ Almost never ☐ Rarely ☐ Sometimes ☐ Regularly/often

3. I agree with the following statements (1=strongly disagree, 5=strongly agree)…

1. The health needs of DV survivors should take priority.
1 2 3 4 5

2. I feel confident in my ability to identify physical health needs of a client.
1 2 3 4 5

3. I feel comfortable bringing up discussions of health with clients.
1 2 3 4 5

4. Clients I work with think addressing their health needs is important to their safety.
1 2 3 4 5

5. Health needs should be included in safety planning.
1 2 3 4 5

6. Colleagues or FJC partners are readily available to assist with the health needs of clients.
1 2 3 4 5

7. The majority of victims I work with have experienced some type of physical violence.
1 2 3 4 5

8. Victims I work with will follow-up on needed medical/health services.
1 2 3 4 5

9. In general, victims get the healthcare services they need.
1 2 3 4 5

10. There are good healthcare services available to clients I work with.
1 2 3 4 5

Thank you for completing this survey!

Appendix E: Alliance Health Toolkit
i. Sample Health Assessment Questions

SAMPLE HEALTH INTAKE ASSESSMENT QUESTIONS
(add to Intake Forms)

Referral Information	
Who referred you here today? *(referral sources in red should be added in addition to complete list)* ☐ No one ☐ [On-site Health partner agency] ☐ Social Worker (E.g. Dept. of Children and Family Services) ☐ Family member ☐ Friend ☐ Neighborhood Legal Services (NLS) ☐ Primary Care Physician/ Psychiatrist ☐ [Off-site Health partner agency] ☐ Therapist (Psychologist, Licensed Clinical Social Worker, Marriage and Family Therapist) ☐ Police ☐ Other (please specify): _____	
Basic Health Information	
Have you been to the Emergency Room (ER) in the past 12 months?	☐ **Yes** ☐ **No**
Do you have a primary care doctor?	☐ **Yes** ☐ **No**
If Yes, Date of last visit:_____ / _____ / _____	
Do you have health insurance?	☐ **Yes** ☐ **No**
Are your children insured?	☐ **Yes, under my insurance plan (please list names):** _____ _____ ☐ **Yes, under a different plan (please list):** _____ ☐ **No or not sure.**
Are you pregnant?	☐ **Yes** ☐ **No** ☐ N/A
Are you concerned you might be pregnant?	☐ **Yes** ☐ **No** ☐ N/A
Health Services and Other	
Do you have any health needs (dental, vision, physical, mental) that you are concerned about?	☐ **Yes** ☐ **No** **Explain if yes:**
Do you have any medical condition you are currently being treated for? **(see a doctor regularly or take medication regularly)**	☐ **Yes** ☐ **No** ☐ N/A
Are you taking the medication? **If yes, do you have the medication with you?**	☐ **Yes** ☐ **No** ☐ **N/A** ☐ **Yes** ☐ **No** ☐ **N/A**
Would you like help enrolling in health insurance?	☐ **Yes** ☐ **No** ☐ **N/A**
Would you like help making an appointment to see a doctor/nurse about any health concerns?	☐ **Yes** ☐ **No** ☐ **N/A**

Appendix E: Alliance Health Toolkit
ii. Danger Assessment Health Checklist

SAMPLE DANGER ASSESSMENT CHECKLIST

(Add to Danger Assessment Scoring Guide)

Danger Assessment Checklist: Health Concerns & Safety Planning		
If client answered "YES" to items: # 1, 5, 6, 9, 10, 13, 15	Check if completed	Notes
1) **Probe** about potential medical effects: (for example)		
a. (Q1, Q5, Q9) Did you experience any physical health issues or injury as a result? b. Did you receive medical care after the event? Did you need to? c. Has a doctor ever asked you about domestic violence? d. Has a doctor ever diagnosed you with a medical issue?		
e. (Q9, Q15) Have you ever been pregnant? Concerned you might be pregnant? f. Have you had any issues with a pregnancy, or other sexual health concerns (such as an STI) as a result of the violence/assault?		
g. (Q10) Complete Strangulation Assessment		
h. (Q13) Has he ever prevented you from seeking medical care? i. Has a doctor ever asked you about domestic violence?		
j. (Q15) Has he ever tampered with your birth control, either trying to prevent you from getting pregnant or coercing you to get pregnant?		
k. (Q20) Have you ever been prescribed medication for a mental health concern? Are you currently taking it/have it with you?		
2) Refer Sample script: ***" I've noticed you marked a few things that could lead to serious health effects. This is common and not your fault. While you're here today would you like to talk with someone about any health concerns or make an appointment?"***		
3) Resources Provide information and resources on health and DV. • Futures Health cards • Local resources • Talk with CATS nurse or onsite health provider		

Appendix E: Alliance Health Toolkit
iii. Safety Planning For Health Checklist

SAMPLE SAFETY PLANNING CHECKLIST

(for Counselor/Advocate to complete during/after safety planning)

Counselor/advocate should:

- Follow-up on any health needs when making other service referrals or follow-up appointments.
- Explain that staying healthy is an important part of staying safe.
- Provide resources and on- or off-site referrals as necessary.

Safety Planning Checklist

Check all items you conducted with the client during your visit.

Date: _____

☐ This is a follow-up visit ☐ This is an initial visit

Safety Planning:

☐ Oral Follow-up on any health concerns noted during intake, Danger Assessment, or other.
☐ Provided resources or information
☐ Made referral to (health partner/resource) _____.
☐ Summary of safety planning for health (e.g. obtaining medications, appointments to schedule, gathering children's immunization records along with other documentation in case of emergency exit, numbers of providers, etc.).

Please summarize here:

Follow-up appointments:

☐ Client requested health/medical services on (date)_____
☐ Referred to (health partner agency)_____
☐ Client sought health service (called, made appointment, went to health center).
☐ Client received health service.
☐ Client satisfied with health services received.
☐ Additional needs (follow-up appointment, new/changed health concerns).

Explain:

Referred to:

☐ [On-site health provider]
☐ [Off-site health provider]
☐ Insurance Enrollment specialist
☐ Other:_____

Appendix F: Tulsa Family Safety Center: Forensic Nurse Checklist

Date:_____ Time:_____

Forensic Nurse Examiner Services

The information you provide by completing this form will be used by the Forensic Nurse in prioritizing your medical needs. The nurse examiner program is associated with the Tulsa Police Department however this information will not be viewed by anyone other than the nurse and Family Safety Center staff or volunteers.

☐ If you would rather just discuss these questions with the nurse, please place a mark in the box.

Yes	No	
____	____	1. Are you experiencing any abdominal or chest pain?
____	____	2. Have you been choked/strangled in the last 10 days? Has he/she had hands on your throat or used his/her arm, a rope or cord or something similar on your neck?
____	____	3. Are you pregnant?
____	____	4. Are you bleeding anywhere?
____	____	5. In the recent past (last 10 days) have you been rendered unconscious? (knocked out, fainted, passed out, blacked out)
____	____	6. Are you experiencing pain from any injuries that you have?
____	____	7. Have you considered harming yourself?
____	____	8. Do you have a recent (within the last 10 days) bitemark?
____	____	9. Do you have any difficulty moving any of your extremities?
____	____	10. Do you have any medical condition you are currently being treated? (Anything for which you regularly take medication or see a physician)
____	____	11. Are you over age 65?
____	____	12. Do you have children living in your home?

Print Name:_____

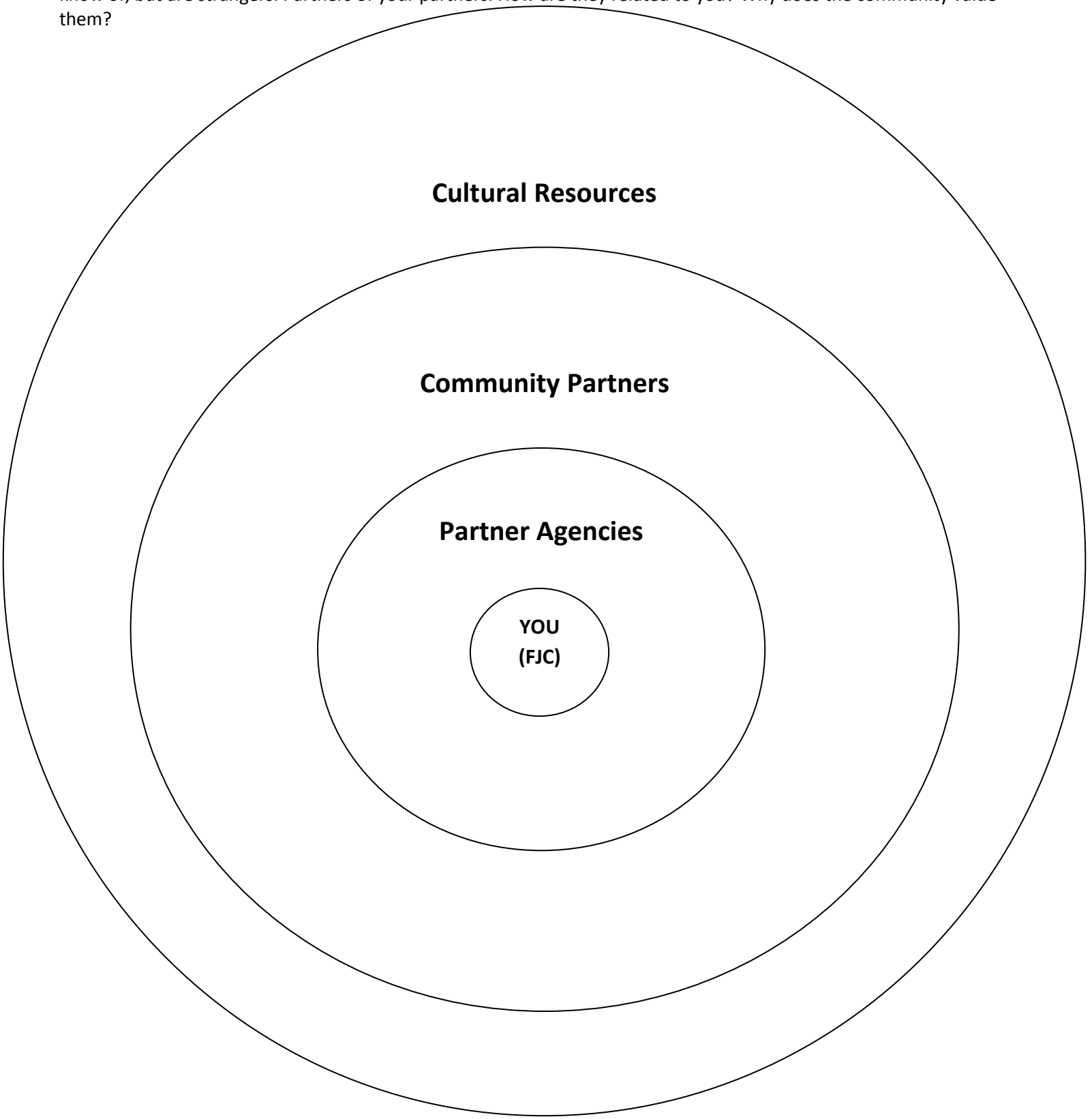
Appendix G: Resource Mapping Worksheet

Community Resource Mapping

Partner Agencies: People and organizations you talk to/work with everyday. What are they doing around health that inspires you?

Community Partners: People and organizations you collaborate with occasionally, you are comfortable reaching out. What resources could they provide you?

Cultural Resources: Health and wellness aspects of your community (e.g. parks). People and organizations who you know of, but are strangers. Partners of your partners. How are they related to you? Why does the community value them?



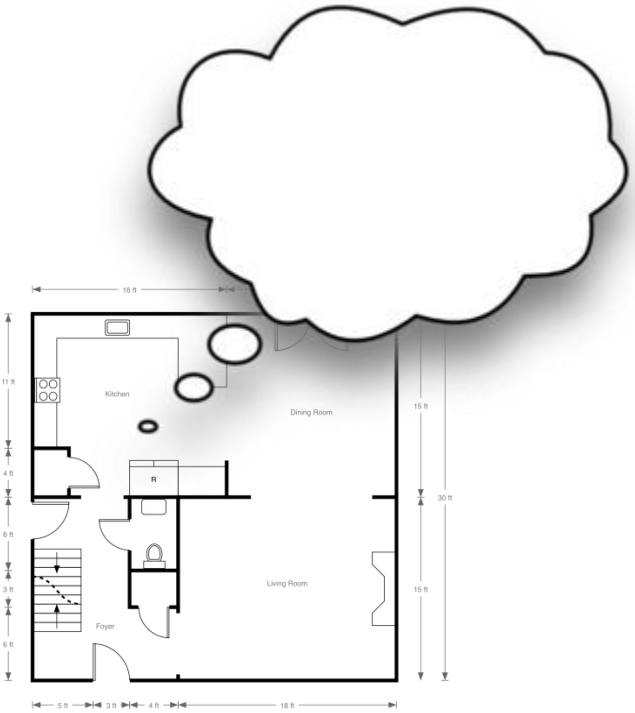
Community Resource Mapping

Identify your Medical Champions:

- Who do you know?
- Who do you talk to regularly?
- Who provides for the “wellness” in your community?
- Who is a non-traditional secret weapon?
- Who is a stranger, but you have heard about doing good work in health?

Develop your Pitch:

- State your clients’ health needs.
- Note the link between violence and long-term health consequences.
- What resources do you already have to address health?
- What’s your dream health initiative?
- How does the plan help address community-wide health priorities?



Appendix H. Health Services Planning Guide

HEALTH INITIATIVES IN FAMILY JUSTICE CENTERS – PLANNING GUIDE

WHAT	HEALTH ASSESSMENT	TRACK HEALTH NEEDS	TRAINING	PARTNERSHIP BUILDING	UPDATE TOOLS/PRACTICES	FORMALIZE PROGRAM/POLICIES
WHEN	1st: 1-3 months	With 1st: 1 week Ongoing: Every 3 months	After Assessment Ongoing (determined by need/resources) (months 4-6)	With Trainings Ongoing (planning committee or part of outreach plan): monthly/quarterly (months 4-12)	Before Training: 1 month With Partnership Building: Quarterly review (months 4-12)	With Trainings Ongoing (months 6-12)
HOW	•Focus Groups (FG) •Survey (S) •Community/Partner Forum	•Review Current Intake Tool •Examine Partner Agency Assessment Tools and Protocols. •Review services provision reports.	•Alliance •Cross-Training with local medical community	•List of local health and medical resources/providers. •Meetings •Outreach activities	•Include Health Assessments •Review Intake Process. •Update FJC policies. •Integrate elements of "wellness".	• Update Operations Manuals • Establish as part of staff orientation, volunteer/Partner trainings. • Include in Strategic Plans • Apply for grants
WHO/ HOW MANY	•Survivors / FG: 8-10, S:30+ •Staff/Advocates / 80-100% •Medical community/provider / 50% •Partners / All	•Appoint Staff •Advocates/Front-line •Program Managers (reporting)	•Intake specialists •Advocates •Counselors •Partner Agency Directors/Managers •Medical Community	•Federally Qualified Health Centers •Hospitals (outpatient, ER) •Health Department •Academic/Research/ Experts	•FJC Director •Partner Agency Directors/Managers •Advocates	• FJC Director • Partner Agency Directors • Appoint Staff • Partners/Stakeholders • Board of Directors
PURPOSE	✓ Identify community and FJC health needs. ✓ Identify gaps in community and FJC services. ✓ Determine barriers to care. ✓ Establish initial planning committee or outreach.	✓ Document current processes. ✓ Determine major service referral sources and referrals made. ✓ Identify potential indicators of change	✓ Integrate Health Intake Assessments and other programmatic changes. ✓ Address knowledge and service gaps. ✓ Enhance community partnerships. ✓ Improve health sector awareness/practices regarding DV (increase referrals).	✓ Plan for on- or off-site direct health services. ✓ Provide training opportunities. ✓ Assess and problem-solve service gaps. ✓ Set joint-priorities	✓ Track and document changes in health needs and service provision. ✓ Expand opportunities for wellness within current programs/services. ✓ Ensure staff compliance with health initiatives.	✓ Plan for funding and sustainability. ✓ Determine need for resources (staff, funding). ✓ Institutionalize health and wellness into FJC culture.

HEALTH INITIATIVES IN FAMILY JUSTICE CENTERS – PLANNING GUIDE

WHAT	HEALTH ASSESSMENT	TRACK HEALTH NEEDS	TRAINING	PARTNERSHIP BUILDING	UPDATE TOOLS/PRACTICES	FORMALIZE PROGRAM/POLICIES
WHEN						
HOW						
WHO/ HOW MANY						
PURPOSE	✓ Identify community and FJC health needs. ✓ Identify gaps in community and FJC services. ✓ Determine barriers to care. ✓ Establish initial planning committee or outreach.	✓ Document current processes. ✓ Determine major service referral sources and referrals made. ✓ Identify potential indicators of change	✓ Integrate Health Intake Assessments and other programmatic changes. ✓ Address knowledge and service gaps. ✓ Enhance community partnerships. ✓ Improve health sector awareness/practices regarding DV (increase referrals).	✓ Plan for on- or off-site direct health services. ✓ Provide training opportunities. ✓ Assess and problem-solve service gaps. ✓ Set joint-priorities	✓ Track and document changes in health needs and service provision. ✓ Expand opportunities for wellness within current programs/services. ✓ Ensure staff compliance with health initiatives.	✓ Plan for funding and sustainability. ✓ Determine need for resources (staff, funding). ✓ Institutionalize health and wellness into FJC culture.