Caring for Survivors of Domestic and Sexual Violence:
A Strategic Leadership Summit

Strengthening Collaborations Between Health Care
and Domestic/Sexual Violence Organizations in Rural Massachusetts

Meeting Summary and Action Plan
July 2015

Nearly all rural survivors of domestic and sexual violence (D/SV) have contact with a health care provider, whether in primary care, obstetrics or emergency medicine. Hospitals, health centers and health care providers are well positioned to help connect survivors with support services, address the health consequences of violence, increase D/SV awareness, and engage in effective prevention efforts. The Affordable Care Act (ACA) encourages brief screening and counseling for violence by including it in women's preventative health. A survey conducted in the winter of 2015 yielded responses by 70 individuals representing rural health care organizations, suggesting a high level of interest and engagement in exploring the impact of domestic and sexual violence in our communities.

For this reason, the Rural Domestic and Sexual Violence Project of the Massachusetts Department of Public Health (MRDSVP) held a Strategic Summit on June 16, 2015 for 55 leaders representing organizations serving the rural communities throughout the Commonwealth. Supported by the Office on Violence Against Women, US Department of Justice and the Western Massachusetts Public Health Association, the Summit provided an opportunity for strategic planning to enhance collaborations between rural health care and domestic/sexual violence organizations.

As Ms. Amy Waldman, Director of The Rural Domestic and Sexual Violence Project noted in her opening remarks, the goal of the Summit was to promote engagement between community-based programs and health care organizations and to serve as a springboard to explore practical ways to move these collaborations forward. Through partnerships, these systems can develop innovative programs that more effectively address complex needs of survivors. This echoes the Massachusetts Department of Public Health Circular Letter issued in November 2014 that urges hospitals to collaborate with community providers to ensure best practices, and quality care to those impacted by domestic and sexual violence.

The Summit began with two consecutive keynote presentations by Ms. JAC Patrissi and Dr. Madeleine Biondolillo. Both speakers deeply inspired the meeting participants and set the tone for an energizing day. Ms. Patrissi spoke from her experiences as a survivor, an advocate and mental health administrator. She reframed our understanding of resiliency and shared specific examples of encounters with the health care system. In addition to identifying places of disconnect with providers, Ms. Patrissi shared examples of authentic, relational encounters which led to healing. Likewise, Dr. Biondolillo spoke from her professional and personal experience. She presented specific opportunities to leverage support and resources from health care organizations in Massachusetts. She noted ways

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that programs could use the MDPH Circular Letter to improve health care responses to survivors, make domestic and sexual violence a Community Benefits priority in health systems, and interpret the ACA to advance the field.

Following the keynotes, participants spent 90 minutes in facilitated discussion groups. We were fortunate to have the following professionals leading these discussions: Julie Kautz Mills, MDPH; Erin Miller, Newton Wellesley Hospital; Monica Moran, Ware and Southern Hilltown DV Task Forces; Beth Nagy, MDPH; Tina Nappi, Consultant on The Strengthening Collaborations Project; and Joanne Timmons, Boston Medical Center. They were given case vignettes to spark conversation, along with the following questions:

1. As a rural community, what else can we be doing to meet the needs of D/SV survivors? Where are the gaps? What are the unmet needs?
2. What can we do together to respond to the needs of D/SV survivors? How can we strengthen collaboration between community-based domestic and sexual violence organizations and health care?
3. What are some next steps? Is there one action item you can commit to doing in the next 6 months?

A dynamic panel discussion in the afternoon session with three rural program leaders offered models for meeting the needs of survivors in rural communities. Ms. Becky Lockwood spoke about the sexual assault and prevention services offered at the Center for Women and Community at UMASS, Amherst and the Hampshire County Sexual Assault Response Team. Ms. Katrina Mattson gave an overview of the assessment/screening and services at Tapestry Health Systems in Berkshire County and the strong collaborative relationship they have established with their local community based domestic and sexual violence program. Ms. Kim Savery described the evolution of comprehensive domestic violence advocacy services and prevention initiatives through the Southern Hilltown Domestic Violence Task Force, Hilltown Safety at Home and the Hilltown Community Health Centers serving the western hilltowns in Hampshire and Hampden Counties.

The Summit meeting concluded with an Action Planning discussion with all participants. Emerging from this discussion, the following next steps were identified:

1. <u>Capacity-building:</u>
   a. Provide technical assistance to domestic/sexual violence organizations to support them in engaging with health care organizations;
   b. Outreach to Community Benefits Directors' in rural health arenas to expand the conversation and reach out to those health care leaders who were not able to attend this meeting.

   c. Convene stakeholders meetings to discuss resources and funding needed to build capacity across D/SV organizations and health care. Stakeholders include but not limited to Health care providers, Community Benefits Directors, D/SV organizations, state and local

legislators and state and municipal agencies, family planning organizations, hospitals and community health centers,

d. Share content knowledge and tools (such as the MOU template and Circular Letter) to enhance collaboration across systems, and disseminate information about the health care impacts of domestic and sexual violence.

2. Training:
   a. Increase training to enhance knowledge about the health impacts of violence;
   b. Cross-training between D/SV organizations and health care systems;
   c. Offer a "train the trainers" program to enhance skill building for D/SV organizations to train health care providers.

3. Strategic Planning/Leverage:
   a. Map out the potential partners to identify existing relationships upon which to build, and gaps in services/connections to document what is missing;
   b. Invite state legislators to forums to identify community needs;
   c. Strategic planning discussions with the Office of Rural Health of MDPH;
   d. Identify relevant data about prevalence and costs of health care for individuals experiencing sexual and/or domestic violence;
   e. Promote models, services and best practices that are working well.

Attached to this document are:

1. The meeting agenda;
2. List of Summit participants who agreed to share their contact information;
3. PDF of Dr. Biondolillo's PowerPoint;
4. Rural health survey summary.

For further information or discussion about the Summit meeting, please contact Amy Waldman at amy.waldman@state.ma.us or (413) 586-7525 X3142.

Caring for Survivors of Domestic and Sexual Violence
Strengthening Collaborations between
Rural Health Care and Domestic and Sexual Violence Organizations

A Strategic Summit Meeting for Leaders in the Field

Smith College Conference Center
Tuesday June 16, 2015
9:00 a.m. – 2:30 p.m.

Opening Remarks **9:00-9:15 a.m.**
Amy Waldman, Project Director, MA Rural Domestic & Sexual Violence Project, MDPH
Leonard Lee, Division Director of Violence and Injury Prevention, MDPH

Keynote: "Barefoot Science: Reflections on Attunement and Presence in the Medical, Behavioral and Advocacy Fields" **9:15-9:50 a.m.**
JAC Patrissi, AB, Administrative Director, Carson Center Valley Human Services

Keynote: "Bridging Public Health and Healthcare- Serving Survivors of Domestic and Sexual Violence as a Transformational Opportunity" **9:50-10:25 a.m.**
Madeleine Biondolillo, MD
Introductory Remarks, Debra Robbin, Executive Director, Jane Doe Inc.

Break **10:25-10:45 a.m.**

Caring for Survivors by Building Partnerships
Facilitated Group Discussions **10:45am -12:15 p.m.**

Lunch **12:15-1:00 p.m.**

Successful Models in Rural Communities **1:00-2:00 p.m.**
Moderator: Carlene Pavlos, Director, Bureau of Community Health and Prevention, MDPH

- Katrina Mattson, Health Services Manager, Tapestry Health Systems
- Kim Savery, Community Health Director, Hilltown Community Health Centers, Inc.
- Rebecca Lockwood, Associate Director, Center for Women and Community, UMass Amherst

Action Planning/Next Steps **2:00-2:30 p.m.**
Tina Nappi, Consultant, Strengthening Collaborations Project & Amy Waldman

MASSACHUSETTS RURAL DOMESTIC AND SEXUAL VIOLENCE PROJECT
FINDINGS OF THE SURVEY OF HEALTH CARE ORGANIZATIONS – MAY 2015

The Massachusetts Rural Domestic and Sexual Violence Project (MRDSVP) disseminated a survey to health care organizations in January and February 2015 via its contacts and the Office of Rural Health of the Department of Public Health.

Respondents: Seventy individuals responded, representing health care organizations in the rural communities. Respondents practice in multiple counties: Hampshire (62%); Hampden (42%); Franklin (35%) and Berkshire (30%); and other (1%). The majority (81%) reported their practice community to be "mostly rural" or "rural and suburban". Respondents reported their primary setting to be a "hospital" (45%), a "community health center" (43%), a "community mental health center" (5%) and "emergency medical service" (5%), and "other" (2%).

Policies and Protocols for Responding to Domestic and Sexual Violence: n=61
Just over 49% (30 respondents) stated that they have policies and/or protocols for responding to patients. About 30% (18) stated that they have policies and/or protocols for responding to employees. Thirty-one (31) respondents, or 51% stated that they knew that their organization did not have any policies or protocols (8%), were not sure if they had a policies or protocols (37.7%) and were in the process of developing a policy or protocol (4.9%).

Current Practices: Sixty-five percent (65%) of the 60 respondents to this question stated that they routinely assess patients for domestic and/or sexual violence. We asked providers to respond to a series of statements about their typical responses when they respond to disclosures of domestic and/or sexual violence. The following highlighted answers provide opportunities for further discussion about the context and methods used in practice:

- To the statement, "I assess immediate safety risks before the patient leave the office," about 48% stated that they would "always" or "sometimes" assess immediate safety.
- To the statement, "I tell the patient that the abuse is not her/his fault," 54% stated that they would "always" or "sometimes" tell the patient this.
- To the statement, "I make a follow-up plan with the patient," 17% stated they always make a plan; 23% stated that they sometimes make a plan.

Technical Assistance and Resources n=43: We asked respondents which of the following would they find helpful in their health care organization:

Technical assistance to develop a policy and/or protocol for responding to domestic and sexual violence	28.6%	12
Expert consultation about how to manage specific patient situations	47.6%	20
Educational materials (pamphlets, brochures and posters) to increase visibility of the issues	47.6%	20
Transportation for patients to access medical care and/or services in the community	59.5%	25
More staff who can take the time to follow-up and reach	50.0%	21

out to patients.		
The phone numbers for domestic and sexual violence advocates and programs in the community	28.6%	12
The phone numbers for offender/perpetrator programs in the community	28.6%	12
A domestic and sexual violence advocate/specialist on-site where I work	28.6%	12
A meeting with the local domestic/sexual violence program to learn more about their services	31.0%	13
A meeting with the local offender/batterer intervention program to learn more about their services	28.6%	12
Support to develop a meaningful collaboration/MOU with community-based organizations	28.6%	12
Continuing education and training opportunities	69.0%	29

Training/Continuing Education n=43: Of the respondents to a question about the last time they received training on how to respond to domestic and/or sexual violence, 23% said that they have never received such training; 42% said that it has been more than a year since they attending such training; and 35% stated that they had been training within the last year. From a list of possible training topics, 43 providers indicated their interest as follows:

The dynamics and tactics of abuse	30.2%	13
Trauma-informed practice	37.2%	16
Safety Planning with Victims	48.8%	21
Long-term impact of trauma on individuals and families	34.9%	15
How to assess and respond to individuals who may be abusive or be using violence in relationships	72.1%	31
How to balance confidentiality with concerns about safety	67.4%	29
Responding to an employee or co-worker who is dealing with domestic and/or sexual violence	51.2%	22
Barriers and strategies to getting help for victims in rural communities	58.1%	25
Resources, benefits, and rights available to victims of domestic and sexual violence	58.1%	25
Mandated reporting and domestic violence	51.2%	22
Provider liability in responding to violence	34.9%	15
Documentation in the medical record	51.2%	22

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