A Hospital-Based Domestic Violence Program Is Crucial To Keeping Women Safe

BY KRISTIN CARMICHAEL, L.I.S.W., M.B.A.

Author's note: *To protect her privacy, I am not using Gina's real name and identifying information. Her story, however, is true.*

It's somewhere around the 20th time I've seen Gina in the past year, my first working in a medical setting at CHRISTUS St. Vincent Regional Medical Center (CSVRMC) in Santa Fe, N.M. I am at her bedside in the ICU where she is on a ventilator and lying motionless. A nurse tells me that this time Gina's boyfriend, Anthony, has stabbed her multiple times, only stopping to flee when the police arrived. Not only does Gina have life-threatening physical injuries, but her blood alcohol content is at lethal levels. It strikes me, as I sit with her, that I'm not sure she wants to survive this most-recent assault. Even though I've seen this before, too many times, I can't help but cry, knowing that Gina's life has never been what she deserved, and that as bad as her injuries are, no one else will be coming to visit her.

GINA'S HISTORY

Gina is not a woman who always has been homeless, addicted to alcohol or in a relationship with an abusive man. Although she was horribly mistreated as a child, she battled back in her adult years to make a satisfying life for herself and her children. Against all odds, she finished college, raised her children free from violence and built a career as a healing professional. She is smart, funny, resourceful and a true survivor. There will never be a statue built for Gina, but if monuments were doled out based on who did the most with what little they were given, there would be.

All Gina's positive and hard-earned supports are gone now. Her family understandably wants nothing to do with her because of Anthony and her drinking. She is no longer able to hold a job, and she lives in a homeless camp. Her safety on the streets once was ensured by her relationship with Anthony. Now, her life is in jeopardy because of him. Gina, like many high-utilizers of emergency departments across the nation, has incredible amounts of anxiety and emotional trauma that seem to prevent her from being able to stick to any treatment or housing program. It would be all too easy for Gina's caregivers at the hospital to despair, cast judgment, ration their compassion, shifting it to those more likely to succeed.

OPENING THE DOORS TO HEALING

Despite what appeared to be overwhelming odds pushing Gina beyond anyone's help, CHRISTUS St. Vincent Regional Medical Center's staff worked tirelessly, strategically and in coordination with one another, as part of our Bridge to Safety program, to alter the trajectory of this patient's life. Orchestrated by the domestic violence coordinator, 15 employees from nine different departments pulled together over the course of several weeks to create an environment where Gina was kept safe. Gina received an order of protection, worked with police for Anthony's arrest,

accessed diagnosis and treatment for her behavioral health issues, created a safety plan, had her spiritual needs attended to and received excellent medical care.

At discharge, Gina was transferred to our Sobering Center where, with additional case management, she was placed in a long-term treatment facility for recovery from her alcohol addiction.

From coast to coast, providers are coming to understand that the greatest determinant of health may not be a patient's genetics, financial means or diet, but the person with whom they are in a relationship.

Gina didn't return to Anthony, despite his threats and manipulations, and she has now relocated outside Santa Fe. All along the way, Gina was consulted about what she needed, and the relationship we had established with her over the previous year was leveraged to create collaborative decisions based on trust and mutual respect.

Gina deserves incredible credit for making these amazing changes in her life. However, without the thoughtful and unwavering support of the Bridge to Safety program and CHRISTUS St. Vincent Regional Medical Center, she likely would have been killed by her partner, perhaps in the days or weeks following her discharge from the hospital. This is the kind of lifesaving result that can be achieved with a hospital-based domestic violence program.

THE LANDSCAPE

Women want services that are responsive, compassionate and targeted to meet their needs. The data show that over their lifetime, 1 in 3 women will be diagnosed with cancer;[1] they also show that 1 in 4 women will be victims of domestic abuse.[2] Medical organizations must be ready to treat both — they cannot turn a blind eye to domestic violence, a pivotal women's health issue, without stunting their success and compromising their adherence to our Catholic healing mission.

Here are some more facts:

- Each year, about 324,000 pregnant women in this country are battered by their intimate partners.[3] That means abuse is more common for pregnant women than either gestational diabetes or preeclampsia — conditions for which pregnant women are routinely screened. However, few physicians screen pregnant patients for abuse.[4]
- Emerging research indicates that hospital-based domestic violence interventions will reduce health care costs by at least 20 percent.[5]
- Fifty percent of men who frequently assault their wives also frequently assault their children.[6] The U.S. Advisory Board on Child Abuse and Neglect suggests that domestic violence may be the single major precursor to child abuse and neglect fatalities in this country.[7]

Today, many hospitals and some forward-thinking health systems are embracing the unique and effective role they can play in helping victims access resources, safety, healing and hope through on-site domestic violence programs. An ever-increasing body of research, as well as the recommendations of respected medical groups and associations and the real-life results from hospital-based domestic violence programs, demonstrate that domestic violence should be screened for and responded to within the medical setting.

The American Medical Association, The American Congress of Obstetricians and Gynecologists and the Institute of Medicine all have spoken out on the importance of screening for abuse. The Joint Commission has instituted a number of regulations spelling out the quality of care expected when working with victims. Futures Without Violence also has taken up the flag as a national organization which acts to provide technical support, tools and training to organizations looking to create these on-site programs.

CHRISTUS St. Vincent has measured the remarkable success of its hospital-based domestic violence program over the past two and a half years through its three performance measures which make up the CSVRMC Domestic Violence Dashboard. To date, we have documented a phenomenal 600 percent increase internally in tracking disclosures of abuse by our patients, significant increases in victims' patient satisfaction scores and a 97 percent decrease in utilization of

BUILDING A PROGRAM IN THREE STEPS

With the support and backing of key executives, it can take an estimated two to three years for an organization to establish a fully integrated and operational domestic violence program. The good news is that hospitals, medical centers and whole medical systems can become responsive to domestic violence quickly and at relatively little cost. Here is a basic three-step process for starting a hospital-based domestic violence program:

STEP 1: Hire a domestic violence coordinator. This position will be the hub of activity for your program, and its occupant will drive the quality of service your organization is capable of providing to victims of abuse, be they patients, visitors or staff.

Under CHRISTUS St. Vincent's Bridge to Safety model, the domestic violence coordinator provides the following services: in-person and on-site individual consults for patients and staff focused on dispersing information regarding the dynamics of abuse, planning for safety, assessing lethality and offering community resources and referrals; convening an internal and community team to identify gaps in service and implementing solutions; offering specialized training to departments such as security, nursing, providers, case management, behavioral health staff; and overseeing data collection and analysis for the Domestic Violence Dashboard.

The domestic violence coordinator also initiates and manages special projects like the revision of policy and procedure on domestic violence and ensuring that the digital medical record is optimized to create meaningful screening for domestic violence, collection of disclosures of abuse and leading staff through an appropriate predetermined model for response and intervention. For examples of CHRISTUS St. Vincent's domestic violence coordinator's job description, the Domestic Violence Dashboard, policy and procedure and abuse response model, as well as other program materials, see: www.stvin.org/workfiles/pdf/community/bridge_to_safety.pdf.

Errors, often committed by well-meaning individuals, can create intense safety issues for patients.

One word of caution: Deciding not to hire for this position, or attempting to farm out aspects of this model, can be disastrous to your organization's ability to create a cohesive program. Without a dedicated individual at the helm, the program's quality, safety and effectiveness are put at unacceptable risk, as is the program's ability to grow and get results for patients and the organization.

This type of initiative requires substantial oversight, expertise on the issue of domestic violence and a victim-centered approach. If staff are not familiar with domestic violence work and the mandatory reporting requirements of your state, mistakes can easily occur — for example, notifying the police about an assault without first securing the patient's consent, or neglecting to notify child protective services or adult protective services when they are legally mandated to be.

Such errors, often committed by well-meaning individuals, can create intense safety issues for patients. The likelihood of these kinds of mistakes is mitigated significantly by having a staff domestic violence expert whose job includes educating others about how to appropriately interview patients, carry out mandatory reporting requirements and document them.

STEP 2: The domestic violence coordinator contacts the national organization Futures Without Violence for technical assistance with new and existing programs. Futures Without Violence connects the domestic violence coordinator with other agencies in your area who can serve as important points of contact. The organization also serves as a critical link between individual programs and information about national emerging trends, best practices and resources. Building a close relationship with your local domestic violence and sexual assault service providers and/or shelters is also essential as you embark on creating a solid foundation and meaningful community partnerships.

STEP 3: Create separate internal and community teams to assist the domestic violence coordinator, hardwire systems changes and construct the Domestic Violence Dashboard. Using teams and having points of contact internally and within the community will assure the program's quality and that its services are both relevant and effective at addressing specific organization and population health goals.

—Kristin Carmichael

the emergency department by our three patients who were most chronically at risk of being killed by their partners.

This push to offer coordinated, effective and consistent services to abuse victims in the medical setting cuts across many of the greatest opportunities and challenges facing Catholic health care today, including:

- Embracing meaningful population and women's health initiatives
- Social justice and mission-centered work
- Health care based on value not volume
- Whole-person and integrated medicine
- Increasing patient satisfaction
- Competitiveness
- Effective management of complex cases and frequent utilizers of services

From coast to coast, providers are coming to understand that the greatest determinant of health may not be a patient's genetics, financial means or diet, but the person with whom they are in a relationship. Medicine is being called to not only check blood pressure, cholesterol or body temperature, but also to explore and respond to the social determinants of health. That means approaching and treating domestic violence in parity with other social and physical ills such as addictions, cancer, diabetes or the flu.

THE WAY FORWARD

Contrary to what some believe, patients like Gina are not uncommon. In fact, the first nationwide study of violence-related injuries treated in hospital emergency rooms found 37 percent of the women who sought care were injured by a current or former spouse, boyfriend or girlfriend.[8]

These victims have many differences in the lives they lead and the obstacles they face. But all too often, what they share are the hallmarks of abuse, fear and shame, which prevent them from speaking out in our emergency departments, medical floors, ICUs and behavioral health units about what is happening to them. We cannot allow this forced silencing to render their health care needs invisible, nor can we be timid in our actions to protect victims and their children.

Abusers ask that we turn our heads, avert our eyes and regard domestic violence as a private matter. What our mission, faith and commitment to women's health demands is that we do the opposite.

Consider this: What would your facility have been able to do for Gina? Would it have been enough?

KRISTIN CARMICHAEL is the domestic violence coordinator at CHRISTUS St. Vincent Regional Medical Center in Santa Fe, N.M., and author of the book *X That Ex: Making a Clean Break When the Relationship is Over* (Xthatex.com). She has been named a 2013 CHA Leader of Tomorrow. Kristin has worked with thousands of survivors of abuse, and her TEDx Talk is available at: http://bit.ly/aba2013. Contact her at Kristin.carmichael@stvin.org.

NOTES

1. National Cancer Institute, "Surveillance Epidemiology and End Results" http://seer.cancer.gov/statfacts/html/all.html.
2. Patricia Tjaden and Nancy Thoennes, *Extent, Nature and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey* (Rockville, Md.: National Institute of Justice, 2000).
3. Julie A. Gazmararian et al., "Violence and Reproductive Health; Current Knowledge and Future Research Directions," *Maternal and Child Health Journal* 4, no. 2 (2000): 79-84.
4. Linn Parsons et al., "Violence Against Women and Reproductive Health: Toward Defining a Role for Reproductive Health Care Services," *Maternal and Child Health Journal* 4, no. 2 (2000): 135.
5. Futures Without Violence, "The Facts on Health Care and Domestic Violence," www.futureswithoutviolence.org/userfiles/file/Children_and_Families/HealthCare.pdf.
6. Murray A. Straus and Richard Gelles, *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families* (Piscataway, N.J.: Transaction Publishers, 1989).
7. U.S. Advisory Board on Child Abuse and Neglect, *A Nation's Shame: Fatal Child Abuse and Neglect in the United States: Fifth Report* (Washington, D.C.: U.S. Department of Health and Human Services, 1995).
8. Michael R. Rand, *Violence-Related Injuries Treated in Hospital Emergency Departments* (Washington, D.C.: U.S. Department of Justice, 1997).

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, September-October 2013
Copyright © 2013 by The Catholic Health Association of the United States