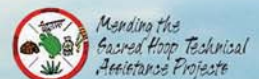


Building Domestic Violence Health Care Responses in Indian Country:

A Promising Practices Report

**Family Violence
Prevention Fund**



Produced by:
The Family Violence Prevention Fund

In collaboration with:
Mending the Sacred Hoop
Technical Assistance Project,
Sacred Circle

Funded by:
Administration for Children
and Families, U.S. Department
of Health and Human Services
and Indian Health Service,
U.S. Department of Health
and Human Services

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or policies of the U.S. Department
of Health and Human Services.



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Produced by:
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In collaboration with:
Mending the Sacred Hoop Technical Assistance Project,
Sacred Circle

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This Report is dedicated to the memory of Tina Costillo, a hard working member of the Family Harmony Project in Crownpoint, NM. She dedicated her life to fighting violence in her community. We want to respectfully acknowledge her family, friends and relatives as we honor her life.

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Executive Summary

Intimate partner violence poses a significant health threat across Indian Country. Increasingly, health care professionals recognize that it is a major public health problem that causes grave and lasting harm to individuals, families and communities. In the largest-ever survey of its kind, a 2008 Centers for Disease Control and Prevention report on health and violence found that 39 percent of Native women reported that they were victims of intimate partner violence some time in their lives – a rate higher than any other race or ethnicity surveyed. Because most American Indian/Alaska Native individuals are seen at some point by a health care provider, the health care setting offers a critical opportunity for early identification and primary prevention of abuse.

To address this problem, in partnership with faculty from Sacred Circle and Mending the Sacred Hoop Technical Assistance Project, the Family Violence Prevention Fund (FVPF) worked with more than 100 Indian, Tribal and Urban health care facilities as well as domestic violence (DV) advocacy programs across the United States to improve the health system response to domestic violence. With funding from the Indian Health Service and Administration for Children and Families, the IHS/ACF Domestic Violence Project began in 2002 and in the years since, has trained thousands of health care providers and community advocates, identified and empowered national experts, instituted sustainable DV response programs in hospitals and clinics, developed model policies and tools to better address abuse and prevent violence, and dramatically increased screening for DV. This report explains how that work that can be replicated.

In addition, since 2007 the FVPF has served as faculty to the IHS initiative, Innovations in Planned Care II (IPC II), which involves 38 Indian/Tribal and Urban health facilities. The IPC II aims to support community and individual wellness initiatives to strengthen and reduce the prevalence and impact of chronic conditions – including DV as a preventative health screening measure. Central to this work are partnerships that each health facility establishes with Tribal and community domestic violence/sexual assault programs.

Contact: Anna Marjavi (415) 252-8900

www.endabuse.org

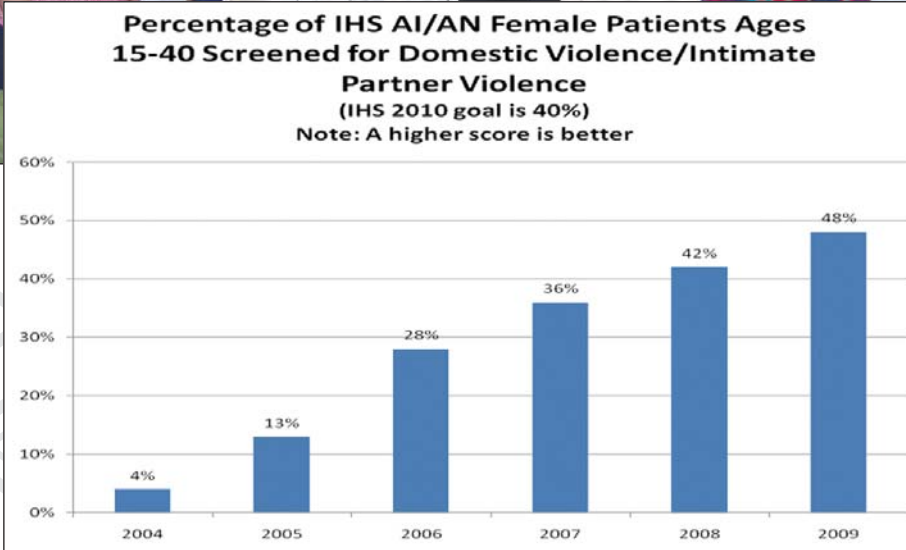
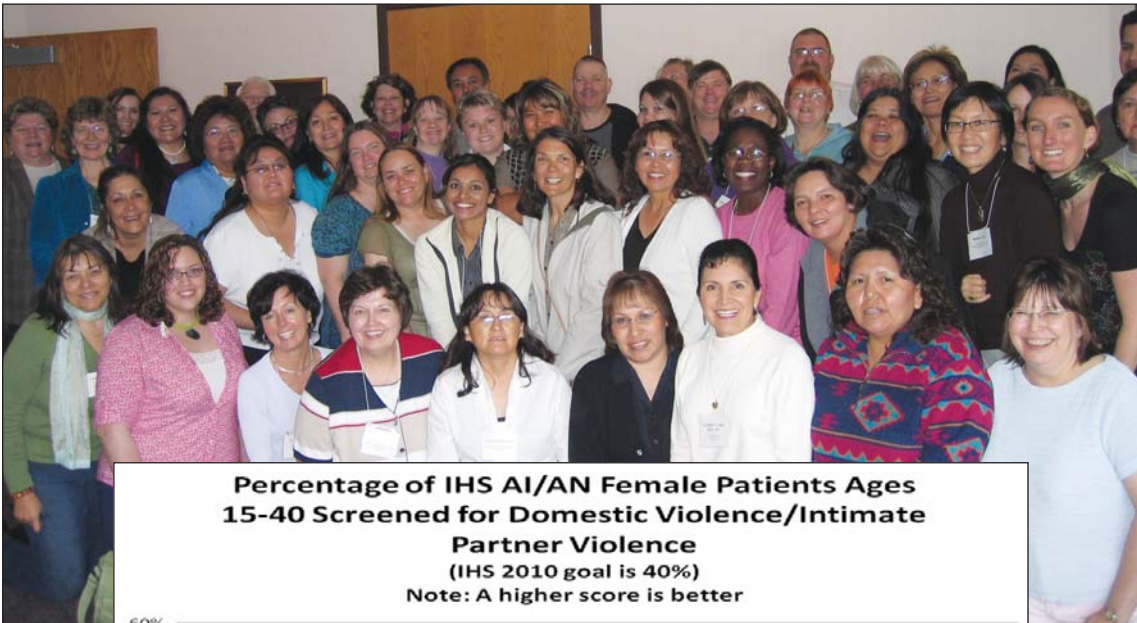
**Family Violence
Prevention Fund**

This report is designed to share lessons learned from this innovative project. We call on all Indian health and community advocacy programs to use this tool to strengthen their own clinical and community responses so as to support the health and safety of victims of domestic violence.

Project outcomes include the development of a Government Performance Results Act (GPRA) measure requiring that every IHS facility institute a policy and procedure on DV, and conduct routine assessment, intervention and referral for intimate partner violence with women aged 15 to 40. When first measured in 2004, only 4 percent of women in the Indian Health Service were screened by their providers for DV. As a result of this project, the DV screening rate climbed to 48 percent in 2009 – a 12-fold increase that significantly surpasses the national screening goal. Preliminary 2008 results for the IPC II sites find that 62 percent of women who seek services there are now screened for DV.

Project accomplishments include:

- Training staff at more than 100 Indian, Tribal and Urban health care facilities, and domestic violence advocacy programs across the United States on domestic violence health system change.
- Developing community-wide domestic violence response teams that include staff from health care, judicial, law enforcement, community programs and Tribal councils.
- Developing patient education materials including two posters targeting men and boys with prevention messages specific to domestic violence.
- Tailoring the Electronic Health Record to integrate domestic violence routine assessment and implementation of screening reminders.
- Raising public awareness and promoting social norm change through community walks, billboard campaigns, candlelight vigils, radio/TV shows, Public Service Announcements, and staff participation in health fairs, rodeos and pow wows.
- Helping victims of domestic violence and sexual assault get the help they need to support their healing from the abuse and promote their health and wellness.



More than 55 people representing 30 Indian health facilities and community-based DV/SA programs convened in Juneau, AK for training and education as part of the IHS/ACF Domestic Violence Project.

When first measured in 2004, only 4% of women in the Indian Health Service were screened by their provider for DV. As a result of the IHS/ACF Domestic Violence Project, the DV screening rate has climbed to 48% in 2009, a 12 fold increase significantly surpassing the national screening goal.

Your kids make memories every day.

It's not too late to change how they remember you.

Violence against women is not part of our traditions and hurts everyone including kids. Children don't forget the violence they see or hear but they can create new, different memories of you in the future. How they remember you is up to you.

www.endabuse.org **Family Violence Prevention Fund**

Eat your vegetables.

Don't play with matches.

Finish your homework.

Respect women.

AWAITING INSTRUCTIONS.

Violence against women is not part of our traditions. Harmony relies on our ability to respect, honor and nurture all our relatives. We must teach the boys in our life early and often that this is what it means to be a warrior and that violence never equals strength. A safer world is in their hands, help them grasp it.

www.endabuse.org **Family Violence Prevention Fund**

These posters, encouraging men to talk to boys in their lives about respecting women, are two tools generated from the IHS/ACF Domestic Violence Project.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

Dear Reader:

To counter the alarming rates of domestic violence and sexual assault in American Indian and Alaska Native communities, "*Building Domestic Violence Health Care Responses in Indian Country: A Promising Practices Report*," offers a host of best practices to raise awareness, improve clinical responses, and strengthen community partnerships in support of the health and safety of victims of domestic violence and sexual assault.

As a practicing Indian Health Service (IHS) physician in Arizona, I saw firsthand the effects of domestic violence on my patients, their families, and the community. As an enrolled member of the Rosebud Sioux Tribe, I am also very familiar with Rosebud's White Buffalo Calf Woman Society and its implementation of the first documented domestic violence program in Indian Country. The Society, along with Rosebud Indian Hospital, were original partners on this Family Violence Prevention Fund (FVPPF) project.

The FVPPF, in collaboration with Sacred Circle and Mending the Sacred Hoop Technical Assistance Project, has worked with more than 100 IHS, Tribal, and Urban (I/T/U) health care facilities and domestic violence advocacy programs across the United States on domestic violence health system change. The project has trained thousands of health care providers and community advocates, advanced a national group of experts, instituted sustainable domestic violence response programs in hospitals and clinics, developed model policies, and established a host of practical techniques that can be replicated in a variety of settings to better address abuse and help prevent future violence.

These best practices are a compilation of the stories and strategies implemented at the hospitals and clinics that piloted this work, which began in early 2002, and highlight their demonstrated efficacy through 2009. The intent is to share lessons learned so that all I/T/U health care facilities and domestic violence advocacy programs will begin undertaking this work, learning from these pioneer facilities, and inspiring system change and community leadership.

The IHS is honored to have joined with the Department of Health and Human Services and the Administration for Children and Families in jointly funding this ground-breaking work.

I congratulate everyone involved in this vital effort and thank you for the important work that you have done.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director



DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
1250 Maryland Avenue, S.W.
Washington, D.C. 20024

Dear Reader:

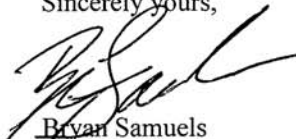
The Administration for Children and Families (ACF) in the Department of Health and Human Services administers several federal programs that promote the economic and social well-being of families, children, and communities. Working with front-line service providers, American Indian Tribes, Alaska Native communities and States, ACF seeks to support strong healthy, supportive communities. A key component of this work is the Family Violence Prevention and Services Program (FVPSA Program) in the Administration on Children, Youth and Families (ACYF), Family and Youth Services Bureau. Since 1984, the FVPSA Program has supported a network of domestic violence services that now includes over 1,500 local domestic violence programs in States and Tribes around the country, a national domestic violence hotline, prevention efforts, and national resource centers.

From 2002 through 2009, ACYF partnered with the Indian Health Service (IHS) to support pilot projects to promote domestic violence assessment and response in IHS clinics and hospitals. The pilot sites partnered with local domestic violence advocates and Tribal communities to promote domestic violence prevention and awareness. The project has trained thousands of health care providers and community advocates, advanced a national group of experts, instituted sustainable domestic violence response programs in hospitals and clinics, and developed model policies and tools to better address abuse and help prevent future violence.

The Family Violence Prevention Fund in collaboration with Sacred Circle and Mending the Sacred Hoop Technical Assistance Project, developed this resource, *Building Domestic Violence Health Care Responses in Indian Country: A Promising Practices Report*, to share the lessons learned from these pilot projects. These best practices are a compilation of the stories and strategies of hospitals, clinics, and domestic violence advocacy programs that piloted this work. Through dissemination of this guide, we hope to encourage all health care facilities and domestic violence advocacy programs to undertake this work, learning from these pilot programs, and promoting system change and community leadership.

The ACYF is proud to have funded this ground breaking work in conjunction with the IHS. I hope that this Report will be a resource to enhance the work that you do to promote the safety and well being of Native American communities.

Sincerely yours,



Bryan Samuels
Commissioner

IHS/ACF Domestic Violence Project Participating Sites

The following Indian, Tribal and Urban (I/T/U) health facilities & domestic violence advocacy programs piloted this domestic violence system change work as early as 2002 to create model materials and foster staff expertise to establish and spread the reform model. Sites marked with (+) also participate in the Innovations in Planned Care Initiative.*

- Crownpoint Healthcare Facility and Family Harmony Project (Crownpoint, NM) (2002-2007)
- Feather River Tribal Health, Inc. and Family Oriented Community Intervention Strategy (Oroville, CA) (2002-2008)
- Gerald L. Ignace Indian Health Center (Milwaukee, WI) (2002-2003; 2008-2009)+
- Houlton Band of Maliseet Indians Health Clinic and Houlton Band of Maliseet Indians Domestic Violence and Sexual Assault Program (Houlton, ME) (2002-2008)

- Ketchikan Indian Community Tribal Health Clinic and Ketchikan Indian Community Department of Social Services (Ketchikan, AK) (2002-2008)
- Mississippi Band of Choctaw Indians, Choctaw Health Center and Mississippi Band of Choctaw Indians Family Violence and Victims Services (Choctaw, MS) (2002-2009)+
- Rosebud Indian Health Service and White Buffalo Calf Woman's Society (Rosebud, SD) (2002-2007)
- Warm Springs Health & Wellness Center and Warm Springs Victims of Crime Services (Warm Springs, OR) (2002-2009)+
- Zuni Comprehensive Community Health Center and New Beginnings (Zuni, NM) (2002-2007)

The following facilities joined the Initiative 2004- 2008 to implement domestic violence and sexual assault responses. Sites marked with (+) also participate in the Innovations in Planned Care Initiative.*

- Albuquerque Service Unit (Albuquerque, NM) (2007-2009)+
- Cherokee Indian Hospital (Cherokee, NC) (2004-2008)
- Cherokee Nation Health Services, Salina Clinic (Salina, OK) (2007-2009)+
- Chinle Comprehensive Healthcare Facility (Chinle, AZ)+ (2004-2009)
- Crow/Northern Cheyenne Hospital (Crow Agency, MT) (2004-2008)
- Chickasaw National Health System (Ada, OK) (2008-2009)+
- Chief Andrew Isaac Health Center (Fairbanks, AK) (2008-2009)+
- Chugachmiut Health Care Division (Anchorage, AK) (2008-2009)+
- Clinton Indian Health Center (Clinton, OK) (2008-2009)+

Project participants began a two day project meeting in Portland, OR with ice breaker exercises and drumming by Vaughn Eaglebear.



- Colville Indian Health Center (Nespelem, WA) (2008-2009)+
- Eastern Aleutian Tribes (Anchorage, AK) (2007-2009)+
- Forest County Potawatomi Health and Wellness Center (Crandon, WI) (2007-2009)+
- Fort Defiance Indian Hospital (Ft. Defiance, NM) (2008-2009)+
- Fort Mojave Indian Health Center (Mojave Valley, AZ) (2008-2009)+
- Fort Peck Service Unit (Popular, MT) (2008-2009)+
- Fort Yuma Health Center (Yuma, AZ) (2008-2009)+
- Gallup Indian Medical Center (Gallup, NM) (2007-2009)+
- Indian Health Council (Mapuma Valley, CA) (2007-2009)+
- Kanza Health Clinic (Kaw City, OK) (2004-2008)
- Kayenta Health Center (Kayenta, AZ) (2008-2009)+
- The N.A.T.I.V.E. Project Inc. (Spokane, WA) (2004-2008)
- Native American Community Health Center (Phoenix, AZ) (2008-2009)
- Northern Cheyenne Service Unit (Lame Deer, MT) (2008-2009)+
- Oklahoma City Indian Clinic (Oklahoma City, OK) (2008-2009)+
- Oneida Indian Health Service (Oneida, NY) (2008-2009)+
- Phoenix Indian Medical Center (Phoenix, AZ) (2006-2008)+
- Rapid City Service Unit (Rapid City, SD) (2007-2009)+
- Red Lake Hospital (Red Lake, MN) (2007-2009)+
- Sells Service Unit: Sells Indian Hospital (Sells, AZ) (2006-2009)+ and San Xavier PHS Health Center (Tucson, AZ) (2006-2008)
- South Dakota Urban Indian Health (Aberdeen, SD) (2008-2009)+
- SouthEast Alaska Regional Health Consortium (Sitka, AK) (2007-2009)+
- Standing Rock Service Unit: McLaughlin Health Center



- (McLaughlin, SD) (2006-2008)
- Swinomish Health Clinic (Conner, WA) (2008-2009)+
- United American Indian Involvement, Inc. (Los Angeles, CA) (2004-2008)
- Utah Navajo Health System (Montezuma Creek, UT) (2004-2008)
- Ute Mountain Health Center (Towaoc, CO) (2008-2009)+
- Wagner IHS Healthcare Facility (Wagner, SD) (2008-2009)+
- Wanblee Clinic (Pine Ridge, SD) (2008-2009)
- Wewoka Service Unit (Weoka, OK) (2008-2009)+
- Whiteriver Service Unit (Whiteriver, AZ) (2007-2009)+
- White Earth Health Center (Ogema, MN) (2008-2009)+
- Wind River Service Unit (Ft. Washakie, WY) (2007-2009)+
- Yakama Indian Health Service (Toppensih, WA) (2008-2009)+

** The Innovations in Planned Care II (IPC II) involves 38 Indian/Tribal and Urban health facilities (2009-10). The IPC II aims to support community and individual wellness and strength and reduce the prevalence and impact of chronic conditions – including domestic violence as a preventative health screening measure. Central to this work are partnerships that each health facility establishes with tribal, and community domestic violence/sexual assault programs.*

Lynn Quan, Domestic Violence Program Director for the Ketchikan Indian Community, Social Service Dept. talks to a colleague in her office.



Examining Why There is Violence Against Native Women |

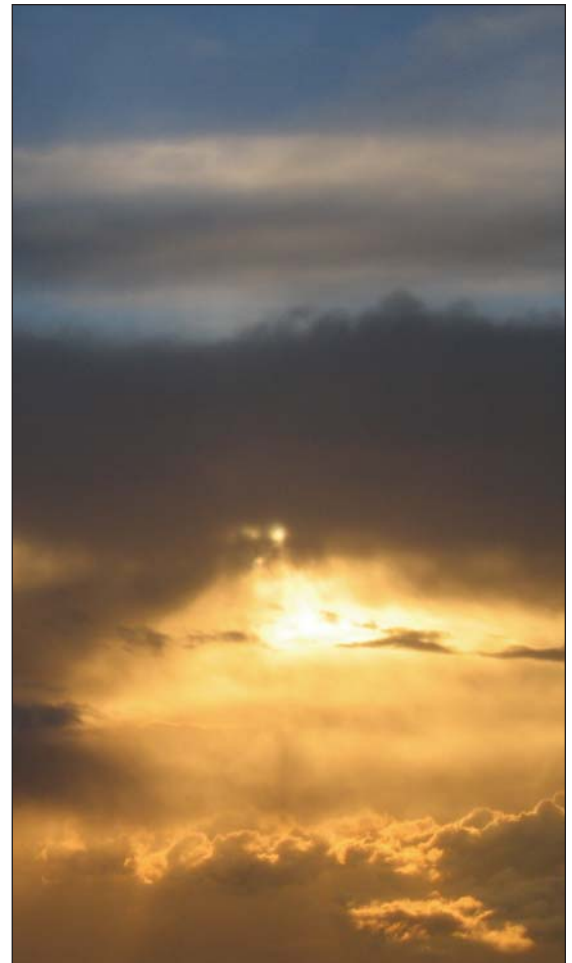
By Brenda Hill, South Dakota Coalition Against Domestic Violence and Sexual Assault

“Understanding the history of violence against women and the dynamics of oppression, helps us to have a clearer understanding of what we do control and are accountable for as individuals. We have then cleared the path to reclaim our natural, traditional ways that lead us to a non-violent and respectful way of living.”

— Brenda Hill, South Dakota Coalition Against Domestic Violence and Sexual Assault

Violence against Native women is a substantial public health problem today. In the largest-ever survey of its kind, the 2008 CDC report on health and violence found 39% of Native women surveyed identified as victims of intimate partner violence (IPV) in their lifetime, a rate higher than any other race or ethnicity surveyed. ¹ Native American victims of intimate and family violence are more likely than victims of all other races to be injured and need hospital care. ² During a three year span, homicide was the 3rd leading cause of death for Native women. Of Native women murdered, 75% were killed by a family member, an acquaintance, or someone they knew. ³ Lastly, 17% percent of Alaskan Native and American Indian women will be stalked during their lifetime.⁴

Many advocates believe that violence against Native women is rooted in the colonization of tribal nations when an unnatural worldview brought a level of violence not seen before by tribal peoples. The path of non-violence and respect for women is the natural lifeway of indigenous people and abuse was not considered a “private family matter” ⁵. Indigenous lifeways are a reflection of Nature, with the Circle representing the natural world, reflecting the relationships within all of Creation. The Circle symbolizes the four directions, balance, harmony and the interconnection and interdependence of all elements and forms of life that exist: physical, mental, emotional and spiritual. Power in the



natural world is life-giving, life-supporting and life-preserving. All things within the natural world have spirits and are related, therefore, violence of any kind endangers all. Harmony within the natural world relies on our ability to respect, honor and nurture all our relatives. Accordingly, Indian women should be respected and valued.

The Native understanding of reality like all things in nature takes the form of the circle; non-violence and respect are the foundation of this reality. The unnatural worldview takes the form of a hierarchy, carrying the notion that people have a right to controlling power or dominance over others based on status, physical or economic strength.



Project participants share closing thoughts at the end of the project meeting in Juneau, AK. More than a dozen project meetings were held between 2002-2009 allowing project participants and faculty the opportunity to explore best practices, hear from national experts on DV/SA and understand the health impact of abuse.

The abuse of Indian women and children can be traced to the introduction of unnatural Lifeways into Native culture⁶. Many people learned about violence in boarding schools through a century long practice of forced removal and abuses. Traditional parenting was non-violent and nurtured the spirit of the child. Boarding schools distorted the ability to act as parents, sons, daughters, as relatives.

Within the natural world, women are acknowledged as spiritually, emotionally, mentally and physically powerful, in a life supporting way. Indigenous women were disempowered as colonization took hold. Traditionally, the role of the woman was one of nurturer and life giver, one of great power and respect. We know that women were free to walk their individual path in life in their own way. A woman who changed the household because of abuse was viewed as honorable for having the self-respect and dignity to end a destructive relationship.

Traditionally, Native men who battered were immediately held accountable for their actions and experienced severe consequences. A man who was violent within the family was not seen as capable of any leadership responsibilities. He had demonstrated that he did not possess the self-discipline, respect, caring or spiritual understanding to effectively lead The People.

An abuser's relatives, shamed by his behavior, would support and protect an abused woman, without question. Everyone had a responsibility to respond, hold him accountable and provide safety and support to the woman. This was a pure form of a coordinated community response to addressing domestic violence.

The feminine spirit is integral to every Tribe's spiritual way. Our connection with Mother Earth teaches us that all things are interdependent relatives and in our own languages and ways, every Tribe reflects this understanding. This Life is a spiritual journey in a physical body where we must learn to be respectful, compassionate and humble relatives.

Our ancestors showed great fortitude and courage as they resisted oppression. We must show the same courage by resisting internalized oppression and relearning how to live respectfully and harmoniously together – without violence. Knowing the legacy of oppression and genocide left behind by centuries of oppression, we are challenged to draw from the strength and beauty we have to return to the Circle we know, where we carry our tradition of respect, honor and compassion toward all living things, especially women and children.



History of Health Care Domestic Violence Reform in Indian Country

“This is a public health story that needs to be told. It is a really big deal what we have been able to do.”

— Theresa Cullen, MD, MS, Chief Information Officer, Indian Health Service

Through the vision and strong leadership from the Native community and non-Native allies, truly transformative institutional change in the healthcare system’s response to domestic violence is taking place on tribal lands and in urban Indian communities today. Native Advocates have been at the forefront of the national domestic violence movement since its birth in the late 1970’s and early 80’s with the early leadership of Tillie Blackbear, and others. They helped lay the philosophical groundwork, develop shelters, advocacy programs, batterer’s intervention programs, criminal justice responses and model tribal and state codes in both Native and non-Native communities. When the opportunity arose to begin working on health care reform in Indian Country, Native advocates again were there including Beverly Wilkins, Eileen Hudon, Jeremy Nevilles-Sorell, Karen Artichoker, Brenda Hill, and Cheryl Neskahi-Coan, among others.

“The medical field is a good place to build a response to violence against Indian women because there is a high ethic to confidentiality, privacy, and patient’s rights. The thinking embedded in the medical field closely aligns with an advocacy approach to addressing violence against women. So it has the potential to be a safe place to build an effective response to helping and protecting women.”

— Eileen Hudon, Domestic Violence and Sexual Assault Activist working across Indian Country

Following a training, Eileen Hudon⁷ and Debbie Lee⁸ began to delineate how a strengthened health care response to violence could be developed in Indian Country. They considered the limitations of the criminal justice system’s response to domestic violence in Indian Country and how the consequences of Public Law 280 (see inset box) left many Tribes without the criminal justice infrastructure to adequately respond. Most significantly, they considered how tribal health and the Indian Health Service (IHS) could be utilized to provide support and improve care for victims. Allies from Mending the Sacred Hoop⁹ and Sacred Circle¹⁰, national technical assistance programs serving Native communities, were also well poised to engage in this new realm, having lead successful domestic violence and sexual assault responses throughout Indian Country.

Native and non-Native leadership saw the strengths that indigenous communities would bring to this work. The natural life ways in indigenous communities made placing domestic violence in health care a natural fit. Native community values recognize that health will only be improved by addressing the whole person, and the whole community.

During the past twenty years, there has been a growing recognition among health care professionals that domestic violence (DV), also known as intimate partner violence (IPV), is a highly prevalent public health problem with devastating effects on individuals, families and communities. Most American Indian/Alaska Native individuals are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even primary prevention of abuse. Studies show that assessing for IPV in medical settings has been effective in identifying women who are victims¹¹ and that patients are not offended when asked



Public Law 280 or PL 280 was a transfer of legal authority/jurisdiction from the federal government by Congress to state governments in six states (California, Minnesota, Nebraska, Oregon, Wisconsin, and Alaska) who could not refuse jurisdiction. This transfer gave extensive criminal and civil jurisdiction over tribal lands within those states to the state governments.¹ PL 280 moved Federal criminal jurisdiction over offenses involving Indians in Indian country to the states mentioned above, and gave other states the option to also assume such jurisdiction in the future. Criminal laws in those states therefore became effective over Indians who were both in or out of Indian country. However, PL 280 did not provide any financial support to the states for these new responsibilities.² Under PL 280, about 28% of the reservation-based tribal population and 28% of all federally recognized tribes in the contiguous 48 states, as well as 70% of all federally recognized tribes including all Alaska Natives and their villages, are covered.²

¹Pecos Melton, Ada and Gardner, Jerry. Public Law 280: Issues and Concerns for Victims of Crime in Indian Country. American Indian Development Associates. Updated 2004. Accessed 5/15/2009. Link: <http://www.aidainc.net/Publications/pl280.htm>

²Goldberg, Carole, and Valdez Singleton, Heather. Research in Brief: Public Law 280 and Law Enforcement in Indian Country – Research Priorities. Dec. 2005. National Institute of Justice. Accessed 5/15/2009. Link: <http://www.ncjrs.org/pdffiles1/nij/209839.pdf>

about current or past IPV.¹² Developing a health-care response to domestic violence in Native communities was an opportunity to work with an institution already involved in people’s lives and an important place to reach women.

In 1996, the Family Violence Prevention Fund (FVPF) piloted their healthcare and



“There are medical providers in every tribal community. By and large you are going to have a network of people in the medical field in tribal communities that are an existing resource carrying many of the same values as advocates, around working with individuals.”

— Eileen Hudon, Domestic Violence and Sexual Assault Activist working across Indian Country

domestic violence reform model in emergency rooms throughout Arizona. Twenty-six hospitals participated which included seven Indian Health Service (IHS) facilities and partnering Native domestic violence community programs. This marked the beginning of an important partnership with IHS facilities and provided the opportunity to determine if the model fit well cross culturally. Providing training and close support, a model was developed to work with multi-disciplinary working groups in every participating hospital along with a community domestic violence advocate. Teams determined how best to improve care for victims and their families, transform their institutions and improve public education on domestic violence.

Beverly Wilkins, a domestic violence expert, and Dr. Lemyra DeBryun, IHS Officer then working at IHS headquarters, emerged as the first allies from within IHS. Beverly Wilkins provided training and technical assistance and worked to have the FVPF’s manual “Improving the Healthcare Response to Domestic Violence” distributed to IHS facilities. Her experience offered valuable insight in the further development of culturally appropriate training and responses. Cheryl Neskahi-Coan, former Director of the Family Harmony Project (FHP) in Crownpoint, NM was another early leader, housing the FHP offices within the Crownpoint hospital and developing one of the first health care advocacy programs in Indian country as part of the FVPF’s 10-State Health Initiative, led by Lisa James, MA and Debbie Lee. Also at this time, the FVPF piloted an Initiative with community clinics funded by The California Endowment. These



projects further illuminated the particular challenges Indian clinics and hospitals face when working with victims of domestic violence in tribal, IHS and urban settings. It was becoming clear that a new domestic violence and health care reform project, working solely in Indian Country, was on the horizon.

William Riley, former Director of the Family Violence Prevention and Service Program with the Administration for Children and Families (ACF), took the first interest in developing this work. Already funding tribal domestic violence programs across the U.S., Mr. Riley recognized the importance of reaching underserved and at-risk communities. He put forth the challenge to IHS to partner on such a program. Finding the leadership within the Indian Health Service was critical to building this program.

Theresa Cullen, MD, MS, then a Senior Medical Informatics Consultant with The Indian Health Service was that person, creating the path that would bring together the funding and potential to develop this premiere initiative. Dr. Cullen reflected on this as “being in the right place at the right time”. With the support of Elizabeth Fowler, then head of the Office of Planning and Evaluation, a plan was developed to involve a variety of IHS, tribal and urban facilities in collaboration with local domestic violence advocacy programs. The work would strengthen health care providers’ ability to recognize victims of domestic violence turning to health care facilities and build domestic violence awareness within Native communities.

Funding was secured in 2002 from IHS and ACF and representatives from the Family Violence Prevention Fund, Mending the Sacred Hoop Technical Assistance Project, Sacred Circle, the Indian Health Service and the Administration for Children and Families came together in San Francisco to develop the initiative. Within the Indian Health Service, several divisions including the Office of Information Technology, Office of Clinical and Preventative Services and the Division of Behavioral Health participated in the pilot project collaboratively, providing both funding, and technical and administrative support. The founding team included Karen Artichoker, Dr. Don Clark, Dr. Terry Cullen, Debbie Lee, Dr. Rachel Locker, Denise Grenier, Brenda Hill, Anna Marjavi, Jeremy Nevilles-Sorell, Anna Pasqua and William Riley.

The first year, 25 applications were submitted. Applicants demonstrated a great need and passion for work within their health care settings. Six project sites were fully funded, as well as three more advanced sites awarded to serve as mentors and further grow their expertise. The group of nine was a diverse group of federal, tribal, and urban facilities with participation from both small and large tribes.

“One of the important things we required from applicants was a relationship with community based advocacy programs. What we found was that many of the health care facilities didn’t realize that there were domestic violence advocates in their communities.”

— Theresa Cullen, MD, MS, Chief Information Officer, Indian Health Service

The completion of the first phase (2002-2003) was marked by the formation of working groups, development of policies and procedures and new materials, and increased assessment for domestic violence. Given these initial successes, IHS and ACF committed to funding a second phase (2003-2004). This resulted in expanded DV screening to new departments and sometimes facility-wide, and training to outlying facilities. A third phase

“One reason IHS was willing to commit was because we run a set of clinical performance measures called GPRA designed to meet the government performance and results reporting requirement for our agency. One of those measures was related to domestic violence and developing policies and procedures for facilities and training appropriate providers on those procedures.”

— Theresa Cullen, MD, MS, Chief Information Officer, Indian Health Service





Participants and faculty at the close of a project meeting held January 23-24, 2008 in Tucson, AZ.

(2004-2005) of funding brought aboard seven additional sites. After three years, fifteen participating healthcare facilities had successfully restructured their system's response to domestic violence and strengthened collaboration with local domestic violence programs. The project then further expanded (2005-2006) to include four more facilities that joined the larger working group, now with model materials and policies to easily borrow from.

The project faculty was enhanced in 2005 by the addition of Elena Giacci, who after years of leading sexual assault efforts with tribes in New Mexico, joined national efforts at Sacred Circle. Two years later, Marylouise Kelley, PhD joined the initiative as a Family Violence Prevention and Services Act Program Director, when William D. Riley retired that year. Dr. Kelley brought expertise working with domestic violence community and tribal programs. Both Elena and Dr. Kelley have an unparalleled commitment to ensure that advocates wisdom is reflected in all project steps, to best support the safety of women and children experiencing violence.

In 2007 the Indian Health Service established a new Women's Health position at its

headquarters in Rockville, MD and hired Carolyn Aoyama, CNM, MPH for this new position. Ms. Aoyama participated in a strategic planning effort focused on addressing the epidemic of chronic illness in the American Indian/Alaskan Native population. Soon after, the Indian Health Service launched the Chronic Care Initiative. This Initiative aims to support community and individual wellness and strength and reduce the prevalence and impact of chronic conditions through several strategies. The chief strategy is the Innovations in Planned Care for the Indian Health System. This learning community for all Indian, Tribal and Urban health care facilities facilitates a system transformation effort. The Chronic Care Initiative team, including, Dr. Ty Reidhead, Dr. Bruce Finke and Lisa Dolan-Branton, RN and their partners at the Institute for Healthcare Improvement, notably Cindy Hupke worked with Ms. Aoyama and the Family Violence Prevention Fund to craft an alignment of the 2 Initiatives, strengthening both approaches. Lending from the models, and promising practices of the 19 sites who participated in DV reform during previous years, the FVPF, MSHTA and Sacred Circle as Learning Community faculty members, provided technical assistance in the



collaborative model to the 14 IPC sites. In 2008 the IPC launched a second phase of work with 24 additional sites, for a total of 38 IPC II sites currently working on system improvement toward a planned care transformation—including domestic violence.

Drawn from seven years of successful work with more than 100 Indian, Tribal and Urban health care facilities, and domestic violence advocacy programs, this report offers a host of promising practices for both the clinical setting, and community-wide responses. Our intent is to counter the alarming rates of domestic violence and sexual assault in Native communities by helping to raise awareness, improve clinical responses, strengthen community partnerships, and ultimately, to reduce isolation, improve safety options for people facing abuse and improve the health and wellness of Native communities.

“Listening to some of the women who have shared their stories, it is inspiring to know that screening is taking place and support and services are provided.”

— Rose Weahkee, PhD Director, Division of Behavioral Health, IHS (former Administrative Clinical Director, United American Indian Involvement, Inc.)

“Before we started, we didn’t have any idea how much domestic violence there was. Now we have services and are responding to domestic violence and seeing an increase in the number of patients screened. It is inspiring to me because not only are we screening but we are providing the services and the outreach to the community and to our staff as well.”

— Donna Jensen, RN, Domestic Violence Program Director, Utah Navajo Health System

This promising practices report is a compilation of the stories and strategies of more than 100 Indian, Tribal and Urban health care facilities, and domestic violence advocacy programs across the U.S. that have successfully undertaken domestic violence health care reform. Our intent is to share these lessons so that all I/T/U facilities will begin undertaking this work, learning from these pioneer facilities and inspiring change and leadership.



“With each clinic that we work with, new leaders emerge. The enthusiasm of the champions within these clinics have taken this project so much further than we had ever anticipated!”

— Debbie Lee, Senior Vice President, Family Violence Prevention Fund

Project participants convened in Portland, OR in June, 2005. From left: Jane Root (Houlton Band of Maliseet Indian DV/SA Program), Joyce Gonzales, CSAC II, IACC, CDVC-1 and Paul O'Rourke, BABB, ENP (Feather River Tribal Health), Denise Hewitt, RN and Rae Marie Martinez (United American Indian Involvement), and Simone Carter, RN (Houlton Band of Maliseet Indians Health Clinic)



Domestic Violence is a Health Care Issue

For over two decades, the Family Violence Prevention Fund (FVPF) has promoted routine assessment for domestic violence and effective responses to victims in health care settings. Numerous professional medical organizations recommend assessing for domestic violence. Among these are the American Medical Association, the American College of Obstetrics and Gynecology, the American Nurses Association and the American Academy of Pediatrics. For health facilities pursuing accreditation with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), standards were instituted in 2004 specific to domestic violence.¹³ The Indian Health Service facilities maintain a policy on domestic violence to routinely assess female patients for abuse and tracks clinical performance as an ongoing Government Performance Results Act (GPRA) performance measure.

*Intimate partner violence (IPV), often also called domestic violence, is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, or was, involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.*¹⁴

Prevalence of Intimate Partner Violence

IPV is a health problem of enormous proportions. In the largest-ever survey of its kind, a 2008 CDC report on health and violence found 39% of Native women surveyed identified as victims of intimate partner violence (IPV) in their lifetime, a rate higher than any other race or ethnicity surveyed.¹⁵ In addition, data gathered by the US Department of Justice indicates that Native American and Alaska Native women are more than 2.5 times more likely to be raped or sexually assaulted than women in the U.S. in general.¹⁶

“It is very compelling to listen to women who share their stories. They might not have been willing to share before and now they feel safe enough. We recognize that they feel safe about that now.”

— Donna Jensen, RN, Domestic Violence Program Director, Utah Navajo Health System

A 2009 study examining 234 American Indian women aged 18-45 accessing primary care services at an Albuquerque, NM hospital found that nearly 80% had experienced any lifetime minor or severe psychological abuse (includes physical, sexual, or injury, or severe psychological aggression).¹⁷ Earlier studies, including a 1998 study by the National Institute on Alcoholism and Alcohol Abuse found a lifetime incidence of intimate partner violence to be 91% and a 12 month incidence at 31% in one Southwestern Native American Tribal community.¹⁸ Similarly, another 1998 study of 169 women on the San Carlos Apache reservation, found 75% of women reported sustaining a physical assault in their current relationship.¹⁹ In addition, the U.S. Department of Justice *1993-1998 Study of Violent Victimization and Race* found Native American women to be victims of violent encounters at the hands of intimate partners more frequently than any other race in the U.S. It goes further to identify that offenders are often not of the same race.²⁰

Health Effects of Intimate Partner Violence

Most women visit health care providers for routine medical care, and victims of domestic violence also see health care providers for treatment of their injuries. This puts health care providers in a unique position to help victims of abuse if they know how to detect domestic violence and provide victims with referrals and support. Intimate partner violence poses a significant health threat in Indian Country. In addition to injuries sustained by women during violent episodes, physical and psychological abuse are linked to



a number of adverse medical health effects including arthritis, chronic neck or back pain, migraine or other types of headache, sexually transmitted infections (including HIV/AIDS), chronic pelvic pain, peptic ulcers, chronic irritable bowel syndrome, and frequent indigestion, diarrhea, or constipation.²¹

The impact of domestic violence and sexual assault on women's reproductive health is pervasive but unrecognized. Pregnancy complications, including low weight gain, anemia, infections, and first and second trimester bleeding, are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and substance abuse.^{22 23} Domestic violence can also result in homicide and is the second leading cause of death for pregnant women.^{24 25 26}

Other sexual and behavioral health implications are equally serious. Victims of domestic and sexual violence are more likely to experience: coercive unprotected sex²⁷, birth control sabotage²⁸, unintended pregnancy^{29 30}, teen pregnancy³¹, rapid repeat pregnancies³², multiple abortions³³, STI's including HIV^{34 35 36 37}, substance abuse³⁸, depression^{39 40}, PTSD⁴¹ and suicidality^{42 43 44}— making the reproductive

health, behavioral health and primary care settings critical places for identification, and early intervention of abuse.

To date, there is limited data related to the health effects from intimate partner violence specific to Native communities. Deaths related to homicide, suicide and physical injuries rank in the ten leading causes of death for Native Americans in all groups under the age of 44.⁴⁵ A 2009 study examining intimate partner violence and overlapping alcohol, drug, and mental disorders among American Indian women from southwest tribes found that unadjusted prevalence ratios for severe physical or sexual abuse were significant for anxiety, PTSD, mood and any mental disorder.⁴⁶

Despite the limited Native-specific data available, close parallels may be drawn to other non-Native studies conducted in the U.S. Native communities face many of the same health concerns as the general population. When working with women who are victims of IPV, an array of corresponding health related problems are recognized. For a more complete picture, it is important that researchers conduct Native-specific studies to closely examine the health effects of IPV in indigenous communities, however, in the present time, it is critical not to wait for the data but to move forward in developing health care responses for intimate partner violence.

Costs

The health-related costs of rape, physical assault, stalking, and homicide by intimate partners exceed \$5.8 billion each year. Of this total, nearly \$4.1 billion are for direct medical and mental health care services and productivity losses account for nearly \$1.8 billion, according to a U.S.-based report by the Centers for Disease Control and Prevention (CDC).⁴⁷

Identifying and Responding to Abuse Can Make a Difference

Women turn to health care providers by the thousands every day, seeking safety during

an emergency room visit, seeking care for old injuries and chronic pain, and for ongoing support from clinical staff whom patients may have known since childhood. In health care, the practice of assessing for diseases and conditions where early identification makes a difference is common. However, providers often are reluctant to assess for domestic violence because there is no specific medical treatment available to prescribe. Routine inquiry, with a focus on early identification of all victims of IPV whether or not symptoms are immediately apparent, is a primary starting point for an improved approach to medical practice for IPV.⁴⁸ Regular, face-to-face screening of women by skilled health care providers, markedly increases the identification of victims of IPV, as well as those who are at risk for verbal, physical, and sexual abuse.^{49,50} Assessment for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence. When assessing for IPV, victims are offered validation of their experiences and an opportunity to be educated about safety options, improved health, potential for escalation of violence and available resources. Providers connect to a better understanding of their patients' chronic pain, substance abuse, uncontrolled diabetes, or other related health concerns.

Providers, well networked with local domestic violence and sexual assault advocacy programs, have the resources to provide the necessary referrals to essential services to address safety planning, housing, and legal alternatives beyond the scope of the provider's capacity. Asking about IPV and having resource and referral materials in health settings also sends a prevention message that IPV is unacceptable and has serious health consequences. In asking patients about these issues that have so long been kept behind closed doors, providers expand their relationships as helpers and then take the first steps to break the cycle of violence and build a healthy community.



“Women are just miracles. Surviving. We have the capacity to follow through with them now.”


— Joyce Gonzales, CSAC II, IACC, CDVC-1, FOCIS Program Coordinator, Feather River Tribal Health, Inc.

Health care providers at the Feather River Tribal Health Clinic (FRTHC) are increasingly recognizing how chronic pain and overall health are impacted by domestic violence. The FRTHC serves Maidu Indians in an urban area on the Berry Creek, Mooretown and Enterprise Rancherias in Butte County California. Before getting involved with the national Domestic Violence Pilot Project as one of 9 sites piloting comprehensive domestic violence responses, providers at FRTHC only addressed domestic violence with patients when injuries were blatant and severe. Through the collaboration between the clinic and the Family Oriented Community Intervention Strategy (FOCIS), a domestic violence advocacy program, a new holistic response to patients has been integrated. This response addresses both the spiritual and physical ailments people face, and moves away from focusing solely on the physical.

When a woman discloses abuse, the priority is to assess her safety, support her spirit and treat her as a relative. The relationship with

Project participants and faculty during a site visit to Kanza Health Center in Newkirk, OK. On the far right is the former DV project leader for Kanza Health Center, Cordelia Clapp, BSN.





medical and dental providers has grown so that now when a woman discloses abuse, the providers will offer to walk her over to the domestic violence program and sit with her as the contact with the advocate is made. Staff at FRTHC recognize that this makes a difference for women who've experienced violence. Clinical staff now see themselves as the first responder to domestic violence. The tribes are now looking at domestic violence in a more complete way.

“We know [providers] are making a difference in the lives of women in their community because patients are offering their appreciation for taking the initiative to screen for domestic violence. Women express a sense of relief that they are able to tell what was going on in their lives, that they were finally asked.”

— Joyce Gonzales, CSAC II, IACC, CDVC-1, Feather River Tribal Health, Inc.

Working Cross Culturally

IPV affects people regardless of race, ethnicity, class, sexual and gender identity, religious affiliation, age, immigration status and ability. Because of the sensitive nature of abuse, providing culturally relevant care is critical when working with victims of abuse. In order to provide care that is accessible and tailored to each patient, it is necessary for providers to consider the multiple issues that victims may deal with simultaneously (including acculturation, racism, language barriers, limited resources, homophobia, and accessibility).

Historically, Native people have experienced mainstream health care systems in varying ways sometimes resulting in distrust in the system's ability to provide them confidential and culturally competent care. This can come from misunderstanding the role of traditional healing to the legacy resulting from a range of practices that were imposed on Native peoples. IHS facilities can struggle to recruit and retain providers, which impacts patients who confront new providers on an

ongoing basis, challenging patient/provider relationship-building. Providers must recognize that each patient who is a victim of IPV will experience both the abuse and the health system in culturally specific ways. This highlights the need to train both preexisting staff and new employees, in addition to locums who may work in facilities for as little as one month.

Disparities in access to and quality of health care may also impact a provider's ability to help abused patients. For example, Native women who are less acculturated or who speak their Native language will experience more difficulty communicating with their doctor and may feel they are treated disrespectfully in the health care setting.⁵¹ People with cognitive or communication disabilities may be dependent on an abusive intimate partner and thus at especially high risk. In addition, some patients may experience abuse from the health care system itself and this may impact their approach to and utilization of the health care system.⁵²

Providers also enter patient encounters with their own cultural experiences and perspectives unique from those of the victim. In a successful health care interaction within a diverse client population, the provider effectively communicates with the patient, is aware of personal assumptions, asks questions in a culturally sensitive way and provides relevant interventions. Eliciting specific information about the patient's beliefs and experience with abuse, sharing general information about IPV relevant to that experience and providing culturally accessible resources in the community, improves the quality of care for victims of violence. In addition, having skilled interpreters who are trained to understand IPV (and who are not family members, caregivers or children) is crucial when helping non-English speaking patients. Culturally sensitive questions for all patients can also facilitate discussion and help providers offer appropriate and effective interventions.

How to Create a Domestic Violence Response in Your Health Care Setting

While it may seem a bit overwhelming to think of establishing a program to respond to domestic violence in your clinic or hospital, this report is set up to ease your concerns and help you get started. This section outlines a model program that has been extensively field tested across the U.S. and in Indian Health Service, tribal and urban health facilities (I/T/U). With the added perspectives of I/T/U health care providers and domestic violence advocates from across Indian Country, this model demonstrates how to create a comprehensive program within primary care, ob/gyn, the emergency department and urgent care, dental and other clinical settings. (For help implementing the following model, and to connect with any of the leaders or sites featured in this publication, call the Family Violence Prevention Fund's (FVPF) Health Resource Center on Domestic Violence toll-free at 1-888-792-2873 or email: health@endabuse.org).

In 1992, the FVPF and the Pennsylvania Coalition Against Domestic Violence designed a model program to strengthen a hospital response to domestic violence; it was then pilot-tested and fine-tuned in 12 hospitals in two states, California and Pennsylvania. Over the next year, another 50 hospitals and clinics across a wide variety of medical settings (primary care, ObGyn and women's clinics, dentistry, etc) implemented the model. The FVPF then worked with California's Department of Health Services to implement the program in 50 California community clinics, and as part of this process, 800 clinical staff were trained. These projects included experience working with 8 Indian Health Service health care facilities, 3 tribal community clinics and many Native advocacy programs. Most recently, the model was adapted for use in over 100 Indian, Tribal and Urban health care facilities, and domestic violence advocacy programs across the U.S.



This approach, applicable to hospitals and clinics enables the staff of a health care institution to respond in a comprehensive manner to domestic violence (i.e., through assessment, identification, referral, documentation, follow-up etc.) by:

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

(left to right) Cindy Jong, Psy.D. (United American Indian Involvement) Al Garcia, MSW (United American Indian Involvement) and Jane Root (Houlton Band of Maliseet Indian DV/SA Program) at the June 24-25, 2008 project meeting in Minneapolis, MN.

1. Setting Up a Collaborative Working Group

This means recruiting key people within the clinical setting plus representatives from local domestic violence/sexual assault advocacy programs, to ensure that training and referral are well coordinated. It is also essential to build support within the institution. To accomplish this, it may be helpful to obtain domestic violence prevalence data in the surrounding area from local domestic violence advocacy programs, law enforcement, prosecution or other community services. This data may only be the tip of the iceberg given that many victims are reluctant to talk about it or seek assistance. Administrators may be particularly receptive to the idea by being reminded of the Joint Commission on Accreditation of Hospitals and Health Organizations (JCAHO) requirements on

domestic violence, as well as the IHS GPRA indicator on domestic violence, and guidelines developed by the American Medical Association, the American College of Obstetricians and Gynecologists, American College of Physicians, and the American Nurses Association.

Because of the different roles played by physicians, nurses, behavioral health staff, public health nurses, coders, and administrators, it is crucial for this Working Group to be multidisciplinary. Many teams noted the importance of involving a data entry coder or quality assurance expert to ensure proper documentation and data entry take place. It is also important to involve as many departments as possible, although this may not happen immediately but rather gradually, as awareness spreads throughout the institution. Before proceeding, an assessment should be made concerning what resources are within the institution (existing protocols, administrative support, potential Working Group members) and in the community (domestic violence programs, tribal council members, other interested health care entities, etc.).

Rosebud IHS Women's Health Staff: (left to right) Connie Semmler LPN, Julie Emery LPN, Louise Ross CNM and Annie Uriel CNM



“When we first started, we had no idea of the domestic violence services. When the light came on, there were a lot of services that no one was aware were going on. It opened up a whole other area for us.”

— Donna Jensen, RN, Staff and Program Development, Utah Navajo Health System

Rosebud IHS Administrative Staff: (left to right) CFO Randy Jordan, SUD Shelley Harris, Clinical Director Dr. Valerie Parker, Administrative Secretary Donna Marcus



When Utah Navajo Health System, located in San Juan County, started developing a response to domestic violence, they realized they needed to bring both medical providers and community advocates on board to learn about the problem of domestic violence in the community and what options were available for women and children in need. Utah Navajo Health System serves the four corners area where the states of Arizona, New Mexico, Utah and Colorado meet. The Navajo Nation crosses into 3 of those states

In 2004, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) instituted new standards for hospitals on how to respond to domestic abuse, neglect and exploitation. These recommendations are outlined with links to on-line resources to help hospitals comply. For more information visit: www.endabuse.org/health

with neighboring Ute reservations. This creates a jurisdictional maze of considerable proportions. Domestic violence was viewed as a problem, though rarely addressed by medical providers or nursing staff. If someone came in to the health clinic with a crisis, they were met with a response that had little knowledge of available community resources.

Utah Navajo Health System's first domestic violence programmatic step was to make contact with the Navajo Nation Domestic Violence Prevention Program. This program then helped identify other agencies in San Juan County to bring on board. Leaders from these community groups began holding monthly meetings with the goal of breaking through barriers in their community and improving services for victims of domestic violence. The group quickly realized there were far more resources and services available than they imagined. As a tool for understanding what steps a woman might follow when seeking support or assistance, their group created a flow chart to see where everybody fit with the services offered. Using different scenarios, if someone was Navajo from Shiprock, from Blanding, and so forth, they were able to walk her through different support agencies. Everyone in the group was surprised to see that the community had a lot to offer women and children in need.

In the Ketchikan Indian Community's Tribal Health Clinic, located near the southern boundary of Alaska, they drew from the skills



and interests of clinic staff to develop their team. Carrying the Tlingit and Haida traditional tribal values of mutual respect for people, they continually work to ensure there is voice from the community by having representation from the Alaskan Native community on their team. The Ketchikan Health Clinic wanted to carry their domestic violence reform from a positive viewpoint and looked for team members who would bring enthusiasm to the work as well as those from different areas of the clinic.

Their team has a broad range of talents and technical skills and are motivated by their interest and desire to help prevent domestic violence. The team determines who will be the best person to take on a task, and offers encouragement, and provides clear goals,



L-R: Donna Jensen, RN and Sandra Buck, Utah Navajo Health System Domestic Violence Leadership Team; Anna Marjavi, Family Violence Prevention Fund; Tara Dowd, NATIVE Project; and Jeremy Nevilles-Sorell, Mending the Sacred Hoop Technical Assistance Project

Members of the Ketchikan Indian Community's DV team: (left to right) Lynn Quan, Helene Simpson, Glen Fazakerley, Bill Hardy, and Debbie Patton

supports, accountability and follow-up. Key to their work has been having someone who prompts the team to keep to a timeline and helps keep things moving. They recognize that time passes quickly and getting the work done is critical to women’s safety. The team is always thinking about the key reason they are doing this—to increase assessment rates and ultimately to increase the safety of women.

2. Developing Collaborative Relationships with Community Domestic Violence Experts

Develop a close, working relationship with your local domestic violence shelter or advocacy program. Identify and reach out to programs that specifically work with Native communities. Many local domestic violence programs provide a range of services which may

include advocacy, support groups, legal assistance, shelter and other services for victims of domestic violence and their children and sometimes batterer treatment programs. In addition to helping inform your institutional changes, advocates may be able to provide you with experienced trainers to conduct the “DV-101” portion of your staff trainings (i.e. dynamics of domestic violence, effects on children, prevalence, etc.) and detail for your providers what support services an advocate offers to clients.

You may also want to participate in community-wide collaborative efforts to address domestic violence. This will help insure that all the necessary resources are available in the community to address the needs of victims, and that all the professionals involved—domestic violence advocates, law enforcement and prosecutors, health care, child protective service—are coordinating and supporting each other’s efforts.

Many tribal communities have not yet developed domestic or sexual violence advocacy programs. However, there are a number of Native-specific national organizations who may support you in this work. These organizations such as Sacred Circle, the National Resource Center on Ending Violence Against Native Women, may help you identify resources and strategies to best support your patients when no community program is in place. They may also help identify how your community can establish such a program.

“It is extremely important for whoever wants to improve their clinic’s response to get connected with their local domestic violence program. Build a relationship so that when they do the screening they are referring people to the proper programs. It would be detrimental if they are not doing this. They need to have a strong working relationship.”

— Simone Carter, RN Houlton Band of Maliseet Indians Health Clinic

SouthEast Alaska Regional Health Consortium (SEARHC in Sitka, AK) domestic violence team members Jennifer Young (Injury Prevention Specialist) and Nancy Jo Bleier (Director, Social Services) work collaboratively with Sharon McIndoo, Shelter Advocate with Sitkans Against Family Violence. Here they staffed a domestic violence resource table in the clinic’s entryway as a way to raise awareness and offer resources to both patients and staff.





Collaboration enhances the safety of women. Somewhere down the line we will find less incidents of domestic violence. Women say, “if I hadn’t gone to the hospital, I wouldn’t have gotten help, I wouldn’t have gotten intervention.”

— Cheryl Neskahi-Coan, Former Executive Director, Family Harmony Project

More commonly known as Navajo, the Diné traditional healing component of respect and honor fit well with this project. One of the core elements to addressing domestic violence is involving community and developing and establishing a coordinated community response. The Family Harmony Project is the only domestic violence program in the eastern part of the Navajo Nation, which encompasses a large rural expanse of 52 communities. The Coordinated Community Response (CCR) model follows the traditional Navajo response already built into their way of life. As Diné people, it is woven into the fabric of their beliefs of respect and honoring the individual.

Once the Family Harmony Project began developing the relationship with the Crownpoint Health Care Facility, they quickly formed a close relationship. Even though it is a separate non-profit organization, Family Harmony has an office in the hospital enabling advocates to provide immediate crisis intervention and appropriate follow-up. The medical staff appreciates the support that Family Harmony provides to patients and Family Harmony welcomes the opportunity to reach more women. Family Harmony provides ongoing training to clinical staff and were furnished with hospital badges, a symbolic and practical acknowledgement of the collaborative relationship.

“We partnered with a domestic violence organization that has had this work going for 27 years, they opened their arms to us. It has been a blessing to us.”

— Cordelia Clapp, BSN, RN, formerly with Kanza Health Center



Located in rural north central Oklahoma, the Kanza Health Center is a tribal-run wellness facility serving the Kaw Nation and other neighboring tribes. As the staff considered how best to identify and assess for domestic violence, it was clear that some of the women who screened positively would need referrals for further advocacy, safety support and healing. Not having a tribal shelter serving the Kaw Nation, staff looked to the non-Native community to help provide assistance and identify resources. To their surprise, they discovered the North Central Oklahoma Domestic Violence Program in Ponca City, just 16 miles down the road.

In existence for 27 years, the domestic violence program had all the resources the health staff needed to respond to victims of domestic violence as well as the ability to provide training to the health center’s staff. Because they are a non-Native program, Kanza Health Center goes in to the shelter to teach the non-Native staff about their culture and heritage to enhance their capacity to work with Native women. As a result, the North Central Oklahoma Domestic Violence Program better understands and respects their ways. Because of this collaboration, the Kanza Health Center has a plan and a vision to take care of domestic violence victims identified through screening.

Kanza Health Center’s domestic violence team leader Cordelia Clapp, BSN (right) and clinical staff.





“As an advocate I want to be involved because I want to try to ensure that things are done safely and that no one’s safety is being inadvertently risked. Advocates get involved to help ensure that it is done in a safe way.”

— Jane Root, Director, Houlton Band of Maliseet Indians Domestic Violence & Sexual Assault Response Program

3. Developing a Protocol

One of the GPRA requirements for every IHS facility is to develop and institutionalize a protocol on domestic violence. A protocol will minimally include a definition of domestic violence, assessment questions and identification of who will ask them, interviewing strategies, safety assessment and planning guidelines, discharge instructions, clarification of legal requirements, procedures for collection of evidence (photographs, other evidence) and medical record documentation, referral information, and a plan for staff education. Protocols should also address confidentiality, and specifically clarify information sharing



Lisa James (Family Violence Prevention Fund) holds up a poster as Cindy Jong, Psy.D. (United American Indian Involvement) presents her group’s poster campaign at the Minneapolis, MN project meeting as part of a group exercise (June, 2008).

only on a need to know basis with the woman’s consent. Protocols should also detail that assessment take place in private, and never in front of accompanying friends, family, or partners, as this may compromise a woman’s safety. These protocols should be developed by a multidisciplinary team (see inset box).

“In the beginning, we developed a policy, and then ER did a policy and the outpatient staff did a policy. They all looked similar but we had specific things to each department. Now we have a new universal policy that is inclusive for the whole hospital.”

— Irene Marietta, RN, Director, Public Health Nursing, Crownpoint Healthcare Facility

When the Houlton Band of Maliseet Indians Health Clinic’s working group stepped forward in their work to end violence against women, they quickly yet thoughtfully wrote a policy and procedure. It was important to the group to ensure that what they were doing would be most helpful to victims, and would work to enhance victim safety. They recognized that institutionalizing the policy and procedures would ensure that the work would continue. See www.endabuse.org/health for model policies and procedures.

Honoring the sovereignty of the Tribe, the policy was brought to Tribal Council for approval. Getting the support of Tribal Council was not difficult because the Tribal

Model Protocols *Don’t reinvent the wheel*

Visit www.endabuse.org/health to review and adapt model domestic violence protocols from large hospitals, small clinics and urban programs specific to:

- Primary Care
- Dental
- Sexual Assault
- Employees

Chief, Brenda Commander had instituted the Houlton Band of Maliseet Indian's Domestic Violence Response Program in 1998. The Tribal leadership was aware of the partnership between the domestic violence program and the Health Clinic so it was a natural next step to review and approve the policy. As the working group progressed, policies were also written on responding to sexual assault and the workplace response to (employee) domestic violence, both of which also received Tribal Council approval.

"It is not just that we screen but we have all the policies and paperwork and everything in place so the work is sustainable."

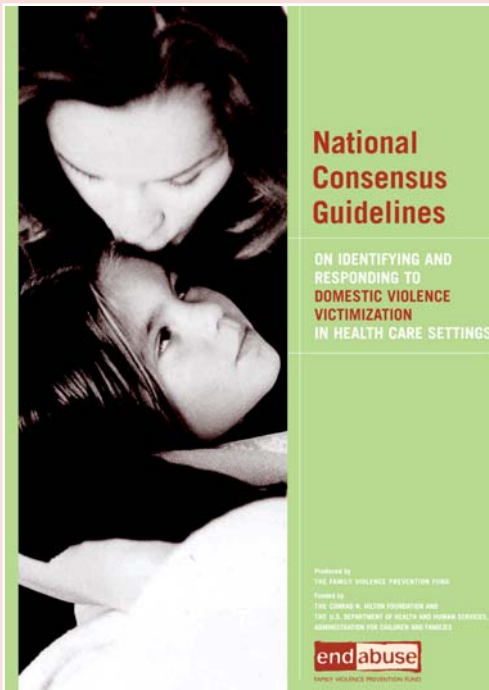
— Simone Carter, RN, Houlton Band of Maliseet Indians Health Clinic

Warm Springs Health & Wellness Center focused their beliefs about working to keep women safe by creating both a clinic-wide protocol, as well as one addressing domestic violence impacting employees. The workplace policy educates supervisors on how to recognize when an employee may be experiencing domestic violence at home and offers strategies on approaching employees, framing discussions, and providing suitable referrals and support. This may include altering work schedules, addressing security issues, and making referrals.

4. Developing Routine, Site-Specific Assessment and Response

What kind of response is best suited for your particular institution to best serve your tribal community? How can assessing for violence be routinely incorporated into your setting? The answers vary by type of clinical setting and the availability of community advocacy programs and need to include a range of informed sensitive clinicians and ideally, advocates. The physical layout should be considered as well, so that private space can be identified.

National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings



Includes DV assessment, documentation, intervention and referral information.

These guidelines are the first of their kind to address assessment for lifetime exposure as well as current abuse and to make recommendations on how to prepare your practice to assess both women and men for victimization.

To view the PDF or order a copy visit: www.endabuse.org/health or call toll-free (888) Rx-ABUSE (also see appendix 2)

Assessment may be conducted verbally or through patient-completed forms, or both. The IHS Resource and Patient Management System (RPMS) database has an exam code on domestic violence with provider prompts so patients are routinely assessed (see appendix 3). It is essential that all victims of domestic violence leave the clinical setting feeling

supported and know that the clinic is a safe place for them to turn for assistance. Providers on site need to provide basic intervention, including an assessment and short discussion about domestic violence safety planning and referrals, even though many may not be ready to pursue a referral. Consequently, all primary care providers should be able to do basic interventions with patients. More in-depth interventions may be carried out by other staff (such as patient advocates, case managers, social workers, etc.), or a community or onsite domestic violence advocate. The Working Group can decide which of these options is best suited to the institution, often starting in one department and expanding to others.

”One of the more exciting things was seeing the staff get really excited and them having ideas and seeing things happen. The informal process of awareness and team building making coworkers more aware has resulted in the screening rates going from 3% to over 50%.”

— Carol Stephens, DSN, RN, Cherokee Indian Hospital

The Zuni Comprehensive Community Health Center routinely assesses all females age 13 and older. Seated in a valley surrounded by mesas, the Zuni Working Group worked to create an environment where patients feel safe disclosing abuse. Corn Mountain is one of Zuni’s sacred mountains. The screening offers the nursing staff opportunities to talk with women about Zuni beliefs that women and children are as sacred as their Corn Mountain. Domestic violence forces women away from their connection to their self and their spirits; the assessment permits staff to talk with women about how sacred they are.

Initially at Zuni, there was reluctance from providers to ask questions about domestic violence. With a lot of patience, persistence and well thought out planning, domestic violence has moved from silence to voice. During screening, nursing staff get to talk with women one on one. They have found that physical therapy staff is in an ideal environment to have conversations one on one with patients about their relationships and possible abuse. In the Ob/Gyn department the nursing staff can talk to young women coming in for Depo Provera injections about

R-L: Cheryl Neskahi Coan (formerly with Family Harmony Project), Rachel Locker, MD (Warm Springs Health and Wellness), Rita Willie (Crownpoint Healthcare Facility) and Tina Costillo (formerly with Family Harmony Project)



their sacredness and what they bring to the community.

“When I look at their faces, when I talk about how precious they are and how sacred they are, it is almost like no one has ever told them this before. There is a lot of emotional abuse going on for our young women. I can talk to them about the emotional abuse as well as the physical abuse they are going through.”

— Cheryl Neskahi-Coan, Former Executive Director, Family Harmony Project

The Feather River Tribal Health, Inc. has many long-standing providers who are well connected to the community. Initially, providers were uncomfortable with the idea of screening because of their familiarity with so many families in the community. When a woman screened positive, it was difficult to think that her husband or partner who was battering her was the same man they knew. Ongoing education and experience increased providers’ comfort in screening, assessing and intervening as they shifted to see it as part of their responsibility as health care providers to improve safety and address associated health issues. An important aspect of providers bringing these issues up with patients was to be nonjudgmental in their approach.



“As a Native program, we don’t just screen adult partners. Because we screen younger ages, one young girl was able to receive the intervention and support she needed. She was spiritually broken when she came in and now today, she is working to change her community. I love that we can get people at that young age. It’s a chance to make a huge difference. She realized that it wasn’t her fault what happened to her. It was an opportunity for her to talk it out and be listened to. Staff was able to pull on her strength, talking with her in a loving way.”

— Joyce Gonzales, CSAC II, IACC, CDVC-1, Family Oriented Community Intervention Strategy (FOCIS) Former Program Coordinator, Feather River Tribal Health, Inc.

“An advocate will need to do a lot of talking with her to engage in planning. You don’t ever want to risk making her life more dangerous. It is important to work with her in ways to address her safety and her concerns.”

— Joyce Gonzales, CSAC II, IACC, CDVC-1, Family Oriented Community Intervention Strategy (FOCIS) Former Program Coordinator, Feather River Tribal Health, Inc.

The United American Indian Involvement (UAI) screens all of their clients. Serving over 200 various tribes and more than 200 distinct languages, the Native American population is fairly dispersed throughout Los Angeles County. UAI is an umbrella organization with a range of programs for people of all ages. Anyone who comes through the organization’s doors receives the same basic intake, which includes assessment for domestic violence. UAI has a traditional healing component utilizing traditional practitioners who can be drawn on to work with victims who need support. Public health nurses have also been trained to do domestic violence assessment and intervention.

“During the course of our health screening, one client that came through our substance abuse program was having issues with abuse at home and needed safety support. She was new to the area, and didn’t know the resources available. Health staff were able to coordinate with the domestic violence and substance abuse programs to get her shelter and into a program for Native women and children dealing with substance abuse and domestic violence.”

— Rose Weahkee, PhD Director, Division of Behavioral Health, IHS (former Administrative Clinical Director, United American Indian Involvement, Inc.)

5. Developing and Institutionalizing a Staff Training Program

Providers should be trained on the dynamics of domestic violence including the dynamics of abuse, the health impact of abuse on victims and their children, perpetrator issues, clinical responses to victims, how to ask the assessment questions, how to properly assess and intervene in the clinic setting, and culturally relevant resources and referral agencies in the community and neighboring areas. Interactive exercise, role-plays, and other “learner-centered” techniques, which enable participants to practice screening and explore personal responses to abuse, are essential in the development of staff capacity. All staff should receive training (including physicians, nurses, social workers, clerical staff, security personnel, translators, clergy, and paramedics). Training should be ongoing and periodic and part of new staff orientation. To enhance staff training, domestic violence advocates and survivors should be utilized as often as possible.

Trainings on a national level and sometimes state or regional level offer an opportunity for staff to expand their understanding of domestic violence while exposing them to work occurring in other areas. The annual Women are Sacred Conference, and Sacred Circle and Mending the Sacred Hoop Technical Assistance Project’s trainings offer ongoing education for all kinds of professionals and

advocates and the FVPF’s biennial National Conference on Health and Domestic Violence offers specific training for the health care community.

When health care providers receive training on domestic violence, it can trigger their own personal experiences with abuse. Therefore, Employee Assistance Programs and staff supervisors should be trained, and services and resource materials should be developed, so that employees who are victims of domestic violence can receive the help they may need.

Concerned about how to best conduct screening, the Crownpoint Healthcare Facility first developed a survey to get a baseline on staff perspectives throughout the hospital. Initially, hospital staff largely felt that domestic violence was a personal issue and that no one had business inquiring. Based on the survey results, the Working Group developed training for each department and nurses were trained as the primary screeners. After the training was conducted, staff perspectives shifted. Staff recognized that domestic violence was a health care issue and that they could better address it with patients if every employee were responsible for addressing it.

“Our training was well received; Staff really wanted the training and felt like they wanted to do this on a regular basis. It became part of new employee orientation which was particularly helpful given the high staff turnover that occurs in so many rural areas. As an advocate organization we appreciated the strong and committed medical providers who worked with us to develop and conduct the trainings”.

— Cheryl Neskahi-Coan, Former Executive Director, Family Harmony Project

The Mississippi Band of Choctaw Indians, Choctaw Health Center demonstrated that open strong communications across departments can produce great results. Through regular monthly meeting with representatives from all Health Center programs, staff share progress and what is going on throughout

Debbie Lee, Sr. Vice President, Family Violence Prevention helped train staff at Crow/Northern Cheyenne IHS. The training included the participation of staff from three outlying native health clinics via teleconference.





the Center. Like Crownpoint, the Choctaw Working Group first surveyed its providers to understand staff attitudes and knowledge around domestic violence.



“Dr. Gordon addressed his brown bag lunch training sessions with his staff based on what we found out by the surveys. In our training, we went over the DV screening policy for the hospital and the DV screening tool, how to document on our encounter forms, how to conduct patient education on domestic violence and document the abuse in the medical record and what services are available for clients through the Family Services and Victim Services Program. We provided training at our different lunch meetings over a period of two months . Our GPRA reporting showed documentation improved tremendously after the training.All that is due to communication.”

— Jamie Hilyer, MSN, Women’s Wellness Center Coordinator, Mississippi Band of Choctaw Indians, Choctaw Health Center

“Today, when people come into Rosebud IHS, many people say that from the time they walk in the door they can really see how the hospital feels about domestic violence. That was not the case in the beginning. The first training we set up, we cooked food and were going to have a ‘Nurses Day’. Two nurses showed up. We then regrouped and went into the departments individually. It was a growing process.”

— Marlene Schafer, RN Former Domestic Violence Screening Program Coordinator, Rosebud IHS



Photo Above: Jeremy Nevilles-Sorell addresses project participants during a national meeting in Portland, OR in April, 2005. Bottom of page: Stills from the Mississippi Band of Choctaw Indians domestic violence video.



6. Resource Materials for Clinicians and Patients

A variety of materials have been developed specifically to educate providers and patients in clinic and hospital settings as well as materials specifically for Native communities on domestic violence awareness and prevention. These include clinical education materials for providers (Consensus Guidelines, pocket reference cards, pregnancy wheel, etc.) and patients (posters, referral cards, brochures, etc.). Model materials may be easily obtained from the FVVPF's National Health Resource Center on Domestic Violence (see p. 44 and online www.endabuse.org/health), Mending the Sacred Hoop Technical Assistance Project (<http://www.msh-ta.org/>), and Sacred Circle, the National Resource Center on Ending Violence Against Native Women (<http://www.sacred-circle.com/>).

In order to adequately respond to patients and assist them in addressing violence in their lives, providers need to be aware of services provided by local domestic violence programs and shelters, legal assistance, counseling and support groups, mental health and substance

abuse treatment, childcare, as well as how resources address language, culture, disability and LGBT (lesbian, gay, bi-sexual and transgender) needs in the surrounding community. This information should be collected into a referral list and made easily available to both clinicians and patients.

At the Crow/Northern Cheyenne Hospital, the Working Group's passion for ending violence against Native women is evident in their materials. Both borrowing from existing materials and blending new ideas, innovative resources have been newly created. One of their first projects, a bookmark, was designed with the image of a Crow female doll made by a member in their Working Group. The doll was dressed in the traditional Crow style and on the back of the bookmark was information about what to do if you witness domestic violence.

The Crow/Northern Cheyenne Working Group were also instrumental in developing the Purple Feather Campaign, a new and evolving resource in Indian Country that aims to improve the recognition of protection orders between tribes. Through collaboration

This safety card is an adaptation of the Family Violence Prevention Fund's national safety card for Native health settings. United American Indian Involvement localized it by adding DV referrals specific to their community. To view more safety cards, visit www.endabuse.org/health

Abuse usually gets worse and can affect your health. Health care providers can help you. Talk to us and let us know if your husband or boyfriend is hurting you. We can:

- Meet with you privately.
- Listen if you want someone to talk to.
- Help you find counseling, a safe place to stay, or other services you may need.
- Keep records (including pictures) of any injuries.

TOGETHER, WE CAN STOP FAMILY VIOLENCE.

Made possible by a grant from the California Department of Social Services. Funded by the National Health Resource Center on Domestic Violence, the National Resource Center on Ending Violence Against Native Women, and the National Health Resource Center on Domestic Violence.

If you are being hurt by your husband or boyfriend, talk with your health care provider. We can help you. *No one deserves to be threatened or abused.*



To find help near you, you may also call the United American Indian Involvement, Inc. at: (213) 202-3970 or National Domestic Violence Hotline at: 1-800-799-7233 or 1-800-787-3224



Violence destroys



Keep our families sacred.

Is someone hurting you? Talk to us, we can help.

- Does your husband or boyfriend put you down and make you feel ashamed?
- Does he tell you what to do and who you can see?
- Has he ever threatened to hurt you or your family?
- Has he ever pushed or hit you, or forced you to have sex?

If you answered "yes" even once, your husband or boyfriend is abusive.

Here's how you can protect yourself:

- Talk with someone you trust about what's going on.
- Call the Hotline of the Inter-Tribal Council of California (1-888-487-7411) to find help near you or someone to talk to.
- Discuss a safety plan with your children, including people they can call or go to in an emergency.

- In violent situations, avoid rooms without exits or with potential weapons, such as kitchens.
- Arrange a signal with a neighbor to let them know when you need help.
- Leave an "emergency kit" with someone you trust. Include money, important papers, keys, medicine, and other things you and your children really need.
- Call 911 if you are in danger.

Together we can stop family violence.

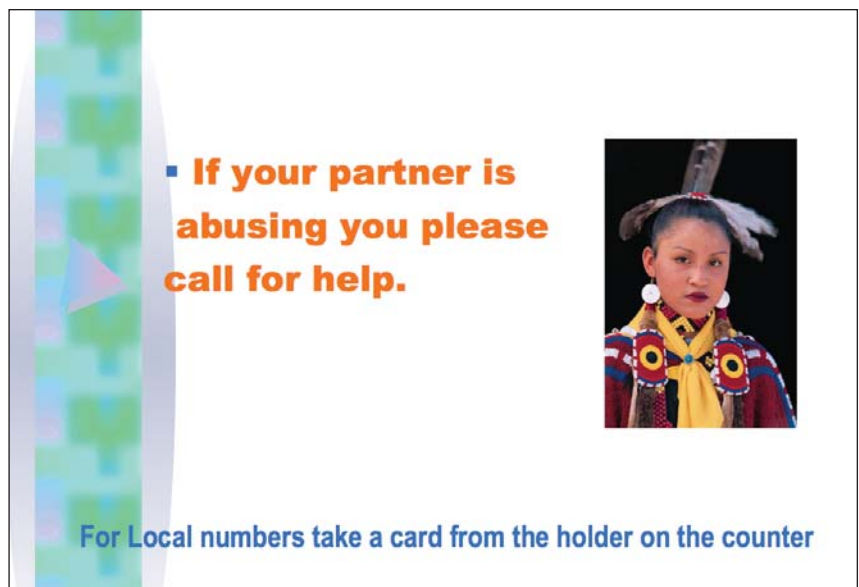
with the FBI, initiated by Agent John Olivera, the Crow Tribe piloted the Purple Feather Campaign which is an enhanced coordinated community response to victims of domestic violence. As part of new procedures of the campaign, victims can carry a Hope Card which replaces the need for victims to carry a copy of their protection order. The card has an 800 number that goes directly to Crow police dispatch to help determine the legitimacy of their protection order. The card also has the code for Full Faith and Credit noted on it. The collaborating partners envision that the concept of the Hope Card will spread to other Tribes.

The Rosebud Indian Health Service enthusiastically worked at changing the culture of their facilities. They purchased plastic brochure holders and placed them in their outpatient exam room, the dental waiting room, the emergency room waiting areas and in the employee men’s and women’s bathrooms as well. These materials helped direct clients to the White Buffalo Calf Woman Society, the oldest shelter for women in Indian Country.

“Initiating the project strengthened the communication and the relationship between our advocates and especially the ER department. When we had a more concrete procedure in place, we were included and our hotline number was there. We are always included in the options that are given to the women.”

— Nichole Emery, White Buffalo Calf Woman Society, Rosebud, SD

The Warm Springs Health & Wellness Center drew on their technology skills as a means to communicate with patients. The committee developed a screen saver with domestic violence messages for use in exam rooms. Using the PowerPoint program, the slides on the computer screen change every 20 seconds and each one is simple and eye catching. The slides play continuously and patients have the opportunity to view them



privately while they’re waiting for the provider to come into the exam room. Providers have received a positive response from patients, with some even asking for copies. Staff have had patients comment that they see themselves in the slides.

Utilizing the intranet (internal employee website) already in place at Warm Springs Health and Wellness Center, an area was developed to give support to staff who may be helping a patient, or family member dealing with domestic violence. The committee held a contest to name the site, naming it RAVE ~ Reservations Against Violent Encounters. The site includes information about domestic violence and basic definitions, patient education materials, the medical facility and workplace policy and procedures on domestic violence, questionnaires and a quick summary to help guide staff when responding to someone seeking help.

“Staff say, when I am looking for domestic violence information I go to the intranet site. They use it a lot. Everything I need is there.”

— Rachel Locker, MD, Medical Director, Warm Springs Health and Wellness Center

To download this screen saver and adapt for your setting, visit: www.endabuse.org/health



Project faculty, Debbie Lee (Family Violence Prevention Fund), Anna Marjavi (Family Violence Prevention Fund) and Jeremy Nevilles-Sorell (Mending the Sacred Hoop TA Project) discuss the work of the project and the health impact of domestic violence on the air at KWSO Warm Springs Radio.



The Mississippi Band of Choctaw Indians Tribal Health Clinic posted this billboard campaign in a busy traffic location on Highway 16 West coming into the Pearl River Reservation area. The billboard directs people to call the National Hotline on Domestic Violence (800) 799-SAFE, a national toll-free confidential hotline networked to DV services across the U.S.

7. Increasing Community Awareness

In addition to the institutional reform you are working on, reaching out to the community to educate and change the social acceptance of domestic violence is an often rewarding and critical strategy. Increasing the community's awareness about domestic violence and available community resources will help support your program's overall goals. Consider participation in health fairs, pow-wows, tribal radio, television and print news segments and other community events where you can distribute materials, or send prevention and intervention messages. Messages may be printed onto banners and hung on the hospi-

tal or other tribal agencies. These messages both reach the public and help to identify new allied partners in other tribal agencies and media.

The Zuni Working Group reached out to a pueblo radio station which operated a monthly "Spin Doctors" show. The show agreed to dedicate a full 2-hour program to the theme of domestic violence prevention and education. Members of the domestic violence team, Safe Start and a member of the radio station produced a program highlighting various community resources and their services. A Zuni Tribal police officer discussed their work with middle school children and a community youth read a poem in both Zuni and English. In between talking segments, songs with domestic violence themes were played.

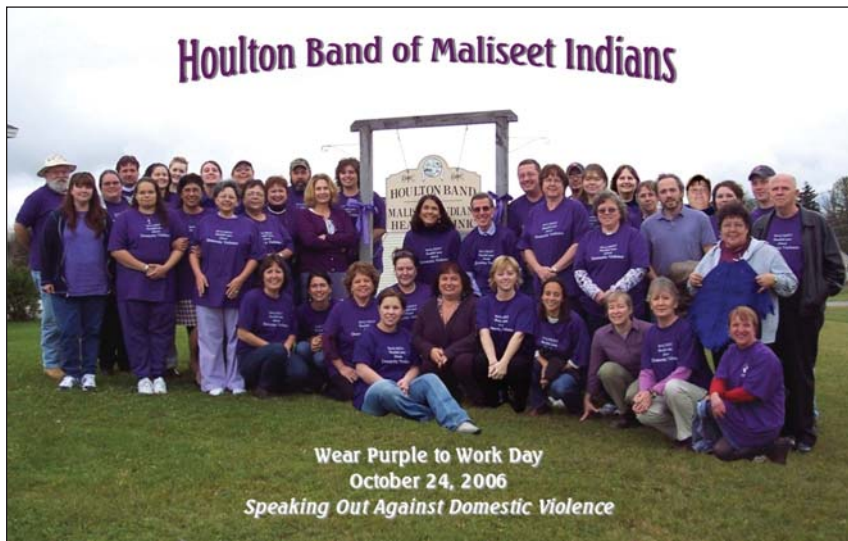
Powwows provide a good opportunity for both raising awareness and conducting outreach. The Kanza Health Center staff set up a table at powwows with literature for the community about resources and health services.

The Mississippi Band of Choctaw Indians' Health Center working group wanted to create a public message on domestic violence to post in a high traffic area. The group identified a billboard near the main highway that runs through the reservation and worked together to think through the concept, image, and message. They included tribal members in the planning and one tribal member drew the graphics. They wanted their message to be simple and decided on "Stop the Violence".

Staff at the Houlton Band of Maliseet Indians Health Clinic were successful in engaging Tribal leaders to raise awareness about domestic violence. During October, Domestic Violence Awareness Month, their Tribal Chief, Brenda Commander presented a

public service announcement on domestic violence through the local community radio station. The Health Clinic also put up posters in the waiting room and clinic bathrooms, ran a DV video in the clinic's waiting area and handed out informational flyers and purple

ribbons. Down the line, Brenda Commander expanded on these awareness activities by printing t-shirts with DV messages and asking all tribal employees to wear them as part of Health Cares About Domestic Violence Day, in October.



Ksuwosun Akonutomakonol' - Shawl Stories is a community awareness project developed by Jane Root, Director of the Houlton Band of Maliseet Indians Domestic Violence and Sexual Assault Response Program. The Shawl Project began in October, 2006 as a way to honor native women and children who are victims and survivors of domestic violence, sexual assault, and racism. Every shawl was created by a community member to tell a story of violence against a Native American woman or child. Jane developed the project with the hope that all tribal communities will adapt it; to learn more email Jane Root: end.domestic.violence@maliseets.com





(Top) Northern Navajo Medical Center's Social Services lead the grand entry to the annual Northern Navajo (Shiprock) Fair with a banner promoting domestic violence awareness. (Below) The Dzilth-Na-O-Dith-Hle Health Center hosted a silent witness display in the waiting area during the month of October to raise awareness of domestic violence.



The Dzilth-Na-O-Dith-Hle Health Center in the eastern part of the Navajo Nation hosted silhouettes/silent witnesses in its waiting area throughout October, domestic violence awareness month. The silhouettes are dressed in traditional Navajo attire, and hold signs such as, "You see the bruises, yet you didn't ask if I was okay." All patients are routinely assessed for domestic violence in triage and posters are up in the bathrooms advertising the services of local crisis centers with detachable phone number tabs.

In coordination with the Northern Navajo Medical Center's Social Services, the Clinic also promoted DV awareness at the 97th Annual Northern Navajo (Shiprock) Fair, which attracted 20,000 Navajo people. On display in the rodeo arena were the silhouettes/silent witnesses and banners. Social workers handed out buttons and bumper stickers to the public, and held a candlelight vigil. Two social workers were invited to lead the grand entry on their horses, and cowboys were asked to wear purple that night. This work is lead by Deanna Paul, MSW at the Dzilth-Na-O-Dith-Hle Health Center.



8. Integrating Domestic Violence Prevention into Wellness Programs

A growing area for many tribes and health care organizations is promoting violence prevention through Wellness—a movement for individuals to become aware of and make choices toward a more healthful existence. This movement is usually based upon cultural traditions and values that include messages about the sacredness of women, and the importance of honoring and respecting all relatives. Domestic violence prevention messages may be integrated into wellness activities as part of wellness fairs, family activities and other preexisting wellness efforts.

Out of tragedy, comes healing. The Crow/Northern Cheyenne Hospital created “Family Fun Night” to provide a safe, fun atmosphere where families could come together and heal from recent community violence. Held annually on the Crow and Northern Cheyenne Reservation, the event takes place at the community gym and

involves over 350 community members each year. The activities include food, games and prizes and an appearance from Santa bearing gifts. Healthy messages about family and community are integrated throughout the event. The Family Fun Nights were conceived as an opportunity to offer family members and community members experiencing grief an opportunity to find support and comfort. There was a huge outpouring of community



The Crow/Northern Cheyenne IHS Domestic Violence Task Force hosts an annual Family Fun Night to help raise awareness of DV and support families.



Members of the Crow/Northern Cheyenne IHS DV Team (from left) Diane Wetsit, RN, Deborah Russell, LCSW and Karen Pereau, RN

support to help make it all possible through the donation of gifts and food. Family members directly touched by recent tragedies were in attendance, candles were lit and a prayer circle was held.



“It was our way of trying to deal and cope with what was happening, offering our support, getting people together and coming together in a good way. The first time we did it, we had such a wonderful response that we decided to do it the next year. In 2008, our fifth year we had 350 people come out for it!”

— Deborah Russell, LCSW, Project Coordinator, Crow/Northern Cheyenne Hospital



“Our paradigm tends to be trying to focus more from a holistic perspective, looking at the strengths and resiliency of the women who come to us. Not looking at them as victims, or a particular diagnosis, but looking at the strengths and resiliency of the women, and building on that.”

— Al Garcia, MSW, Associate Director, Robert Sundance Family Wellness Center, United American Indian Involvement, Inc.

The United American Indian Involvement, Inc. incorporates Wellness in their work with women across their programs. Many of the women seeking their services have many obstacles ranging from substance abuse to complex health issues. Throughout the multiple programs operated by UAI, they try to integrate the cultural aspects of women’s identity to show them their resiliency. Women build on their strengths to empower themselves. This is carried over into their work with youth. Youth are provided with opportunities to strengthen their understanding of their own cultures and understanding of what it means to be a man or woman. The Powwow crew of the Seven Generations Program teaches youth how to make a drum and do traditional dancing. Women come in



and talk to the younger women about their role as women, while men come in and talk to the younger men about their role as men. This includes how they are supposed to treat women and children in the community. UAI also brings in their two traditional practitioners to hold coming of age ceremonies for the youth.

9. Establishing Quality Assurance Mechanisms to Monitor Response

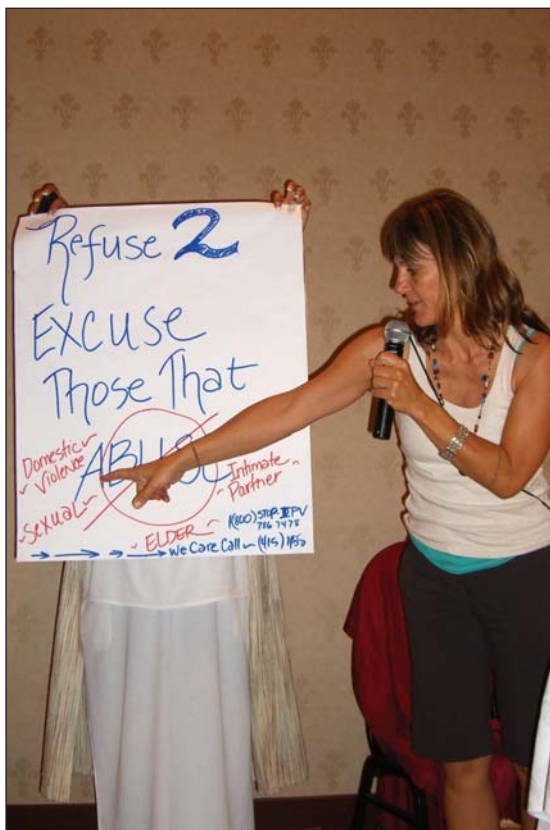
Make routine assessment and appropriate responses to victims of domestic violence the targets of quality assurance reviews. This notifies providers that routinely assessing for domestic violence is now a standard of care and no longer left to their “discretion.” If a baseline needs assessment has been done, ongoing quality assurance reviews can be used to engage clinicians in setting goals and addressing obstacles that are identified. Evaluate the RPMS exam code on domestic violence (see appendix 3) to measure DV assessment rates. Some sites elect to conduct chart reviews to analyze prevalence of abuse, how often assessment is taking place, and whether intervention, referral and follow-up were conducted. Research shows that provider compliance with domestic violence

protocols increases significantly with administrative support, including adequate staffing and training time and by offering providers tools (RPMS DV exam code training, as well as patient education posters etc.) Over time, systems see significant improvements in provider compliance with the domestic violence protocols.

“We have really tried to develop a system of care in our agency. We do try to have a system of care that supports the women and their children and their families when they come in the door. This is an important part of that.”

— Rose Weahkee, PhD Director, Division of Behavioral Health, IHS (former Administrative Clinical Director, United American Indian Involvement, Inc.)

Understanding local IPV data or other available setting-specific prevalence data can help providers establish goals to reach as many victims as possible. Providers or administrators are encouraged to compare their identification rates with the research on prevalence of domestic violence to work towards these improved identification goals. When a comprehensive and well designed assessment and response program is in place, identification rates can reflect national or community prevalence data fairly closely.⁵³ Measuring provider skills, knowledge level and satisfaction with the program will also provide valuable information that can be used to continually improve identification rates and response to victims. Success should not be based on disclosure alone, and there are many reasons why a patient may or may not disclose abuse. Evaluating patient satisfaction and improved health and safety behaviors in addition to measuring identification rates is strongly recommended.⁵⁴



Members of the Cherokee IHS DV team—(left) Becky Walker (Cherokee IHS) and Cindy Feather (Ernestine Walkingstick Shelter)

Stephanie Jimenez (Feather River Tribal Health) presents her group's poster campaign at the Minneapolis, MN project meeting as part of a group exercise (June, 2008).



10. Engaging Youth, Boys and Men

In an effort to prevent violence before it begins, one emerging strategy is for men to mentor boys about relationship violence and how to respect women. Research has shown that men are comfortable and interested in talking to boys in their life and when equipped with the right messages, can be quite effective. The FVPF's "Coaching Boys into Men" campaign invites men to be part of the solution by teaching boys that violence never equals strength. It also sends the message, "Violence against women is not part of our traditions. Harmony relies on our ability to respect, honor and nurture all our relatives. We must teach the boys in our life early and often that this is what it means to be a warrior and that violence never equals strength. A safer world is in their hands, help them grasp it." The campaign also includes a toolkit for coaches about how to talk to male

athletes about healthy relationships (see: <http://www.coaches-corner.org/> for toolkit).

The Warm Springs Health & Wellness Facility adapted the Coaching Boys Into Men public service announcements by inviting several prominent tribal leaders, including the Chief of Police, to do the voiceovers. The announcement was played on their tribal radio station, KWSO.

As part of the Coaching Boys into Men campaign, two domestic violence prevention posters, specific to Native communities were developed. (See posters below). The posters are appropriate for community settings such as health care facilities, tribal offices, schools, gyms, batter's intervention programs, and visitation centers. The AI/AN posters were developed by a committee of leaders from this project and created collaboratively with Mending the Sacred Hoop Technical Assistance Project and Nakota Designs.

To order these posters, visit www.endabuse.org/health or see Appendix 2 for an order form.



Your kids make memories every day.

It's not too late to change how they remember you.

Violence against women is not part of our traditions and hurts everyone including kids. Children don't forget the violence they see or hear but they can create new, different memories of you in the future. How they remember you is up to you.

www.endabuse.org **Family Violence Prevention Fund**



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Eat your vegetables.

Don't play with matches.

Finish your homework.

Respect women.

AWAITING INSTRUCTIONS.

Violence against women is not part of our traditions. Harmony relies on our ability to respect, honor and nurture all our relatives. We must teach the boys in our life early and often that this is what it means to be a warrior and that violence never equals strength. A safer world is in their hands, help them grasp it.

www.endabuse.org **Family Violence Prevention Fund**



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At the Cherokee Indian Hospital, staff believed it was important to engage men in the leadership of their work to end violence against women. Cherokee traditional values reflect the importance of family and the protection of people. And while the Cherokee have been a strong matriarchal tribe, they recognize violence against women as a contemporary concern needing to be centered in protecting and preserving their community. Skip Myers, a nurse at Cherokee Indian Hospital and part of the hospital's Working Group, moved from simply joining the Group, to taking a more active role of developing ideas and strategies. Their committee believes that having men involved in leadership on the work to end violence against women will help model to the community that it is not just a woman's issue.

The Utah Navajo Health System is developing work with coaches and church leadership about how to engage boys and men in work to end violence against women. They've gone to their local school to develop a program working with young men and mentors. They are hoping to work with the coaches, using the materials from the FVPF to influence young boys as they develop relationships with young women. They are also talking to church leadership about their role in shaping the attitudes of young men.

Male staff of the NATIVE Project take their role as mentors to community youth very seriously. They recognize that as men, their actions influence young men's development

“Men working to end violence against women need to be taking the responsibility to address sexism in their environment, taking on the kind of social acceptance that allows it to exist. As a medical provider, they work to get rid of the underlying problem. So then, they need to be making the links to work with victims of violence differently and understand what is the cause of domestic violence. Your doctor would be saying not to smoke, or helping you to quit smoking, so violence against women, sexual assault or rape, they should not be allowing that to happen. They would not just sit there and perpetuate it but act in a way to change the conditions that allow it. They could take responsibility to treat or change the underlying condition, creating the cure, and not just treat the symptoms. That is very personal work for men.”

— Jeremy Nevilles-Sorell, Resource Coordinator,
Mending the Sacred Hoop Technical Assistance Project

of attitudes and views on women. Using their domestic violence resources, they show videos and openly discuss domestic violence. The men try to role model, encourage, and empower the youth they work with about responsible decision making and respect. They help them identify other ways to address their anger and aggression. This modeling is presented in a fun environment with games, exercises, walks, playing basketball and through theater skits. They also participate in community events like powwows and evening programs.



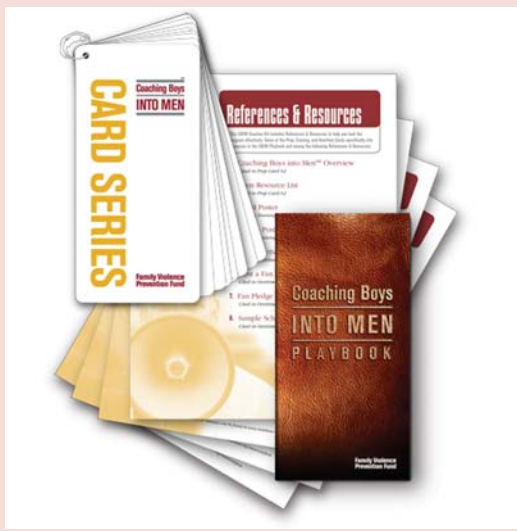
“I believe in change. People can educate themselves, turn their situation around 360 degrees and do something good and productive with their lives. When I work with teenagers, a lot of them don't have the parental support, community support or financial support. That often leads to a lifetime of bad habits. I get excited when teenagers step up to the plate and start making mature decisions so that institutions are not in their lives anymore.”

— Vaughn Eaglebear, MSW, NATIVE Project

Jeremy Nevilles-Sorell,
Resource Coordinator,
Mending the Sacred
Hoop Technical
Assistance Project



Athletic coaches play an extremely influential and unique role in the lives of young men, often serving as a parent or mentor to the boys they coach. Because of these special relationships, coaches are poised to positively influence how young men think and behave both on, and off, the field. From speeches to the team, practice sessions, or simply casual conversation, coaches have many opportunities to impart their philosophies to athletes. For more information visit: www.endabuse.org/cbim



Once a year, the NATIVE Project Youth Leadership Camp empowers and inspires community youth to lead healthy lifestyles. The 3-day camp is based on four tenets: being a warrior, being a nurturer, being a scholar and being a community activist for healthy lifestyles which includes living alcohol and drug free, tobacco free and domestic violence free. The NATIVE Project brings in renowned Native speakers and offers connections to Native culture and community building in the Spokane area. In closing the Camp, an honoring ceremony is held to recognize each person as a leader with a certificate.



“This project helped us better understand each other, why we do what we do. It opened doors with the advocacy program and improved communication. We have a good dialogue about what their needs are, our needs are, what the patient’s are and getting things done as quickly as we can for the victim.”

— Rachel Locker, MD, Medical Director, Warm Springs Health and Wellness Center

The Kanza Health Center is raising domestic violence awareness through an allied program, the Native Youth Preventing Diabetes Camp (NYPD). The Camp creates an opportunity for

“Medical providers are seeing how chronic pain and injuries are related to domestic violence and overall health. And what we are seeing with the women, is that part of their spirit that has been lost, is coming back to them.”

— Joyce Gonzales, CSAC II, IACC, CDVC-1, Feather River Tribal Health, Inc.

more than 100 of the youth from Kaw Nation to learn about their culture and heritage. They now also learn about dating violence and what it means to be Indian, living with respect and honoring women.

Conclusions

The IHS/ACF Domestic Violence Project has advanced a national group of experts, instituted sustainable domestic violence response-programs in hospitals and clinics, and developed model policies and tools to better address abuse and help prevent future violence. Central to this work has been the establishment, or enhancement of partnerships between health facilities and tribal, and community domestic violence/sexual assault programs.

The IHS/ACF domestic violence system change model has spread to more than 100 Indian, Tribal and Urban health care facilities, and domestic violence advocacy programs across the U.S. We call on all Indian health and community advocacy programs to use these lessons to strengthen their own clinical and community responses to support the health and safety of victims of domestic violence.

Future Directions: Responding to Sexual Assault

The IHS/ACF Domestic Violence Project exemplified effective health care and community-based partnerships to help reduce isolation, and improve health and safety outcomes for victims of violence. As the project progressed over the years, funded sites also began to realize the need to undertake sexual assault reform work to compliment their domestic violence efforts. This program shift can help communities reach more patients who suffer all types of

abuse and who access health care services, both on an emergency and primary care level.

Similar to domestic violence, Native women experience alarmingly high rates of sexual assault (SA). SA occurs in many relationships—by a married partner, or boyfriend, on a date, by a friend or an acquaintance, by a stranger, or by a family member such as a parent, a sibling or a grandparent. Many women who experience domestic violence also experience forced sex, or reproductive coercion* by their partners, boyfriends, or dates. As with domestic violence (DV), SA greatly impacts the current and long-term health status of survivors. Adverse health effects stemming from SA and reproductive coercion include physical injuries, unintended^{55 56} and teen pregnancy⁵⁷, rapid repeat pregnancies⁵⁸, multiple abortions⁵⁹, sexually transmitted infections including HIV^{60 61 62 63}, substance abuse⁶⁴, depression^{65 66}, post traumatic stress disorder (PTSD)⁶⁷, suicide^{68 69 70} and poor pregnancy outcomes.

Advocates from across Indian Country have long worked to raise awareness of the high prevalence of SA, the complex criminal justice responses that follow, and the inaccessibility or unavailability of SA exams in health facilities across Indian Country. A 2007 Report by Amnesty International, *Maze of injustice: The failure to protect indigenous women from violence*, helped ignite media attention to the issue. Both of these advocacy efforts contributed to policy improvements marked by new funding for both DV and SA prevention and intervention, most recently via the FY 2009 Omnibus Appropriations Act approved by Congress and President Barack Obama.

There has been much attention by advocates and policy leaders alike, for the need to

* Reproductive Coercion: includes intentionally exposing a partner to sexually transmitted infections (STIs); attempting to impregnate a woman against her will; intentionally interfering with a partner's birth control, or threatening or acting violent if she does not comply with the perpetrator's wishes regarding contraception or the decision whether to terminate or continue a pregnancy. (Family Violence Prevention Fund)

have more sexual assault nurse examiners (SANEs) and other trained first responders in place at health facilities, along with equipment and rape kits to collect forensic evidence. These actions are much needed to help support those who have experienced sexual assault and access health care in a timely fashion following an assault, and especially for those seeking criminal justice remedies.

- However, for women who experience sexual assault on an ongoing basis who may never access emergency health care services for an assault; for those who have survived past assaults; and for survivors with no interest in prosecuting their perpetrator, **the availability of rape exams and forensic evidence collection are not always a primary solution.**
- For these women, a routine screen inquiring about their experience with DV/SA and reproductive coercion, and current safety may be the best way to improve health and safety. Providers can help patients connect the impact of abuse on their patient's current health; and connect them to community DV/SA advocates, or on-site support staff for next steps, including safety planning.

Like the IHS/ACF Domestic Violence Project model exemplified, a core principle to accompany such health system change is collaboration between the health care facility staff and tribal/community DV/SA advocates and shelter program staff. Because of the protocol surrounding forensic evidence collection, greater collaboration with tribal, state, and federal criminal justice personnel would also compliment this model. Such collaboration helps to inform the development of health policies on training and responding to DV/SA; to increase patients' knowledge of tribal/community programs or onsite services to support survivors; to explain the prosecution process and to help coordinate and strengthen tribal-wide responses to victims, including increasing public awareness and prevention efforts.



Notes:

A series of horizontal lines for writing notes, starting below the 'Notes:' header and ending near the bottom of the page.

Creating a Domestic Violence Health Care Response: Worksheet

1. Set Up a Collaborative Working Group

Recruit key people within the clinical setting plus representatives from local domestic violence/sexual assault advocacy programs. Involve multidisciplinary staff: physicians, nurses, behavioral health staff, public health nurses, reception, coders, translators, and others.

2. Develop Collaborative Relationships with Community Domestic Violence Experts

Develop a close, working relationship with your local domestic violence shelter or advocacy program. Identify and reach out to programs that specifically work with Native communities.

3. Develop a Protocol

Develop and institutionalize a protocol. Visit www.endabuse.org/health to review and adapt model domestic violence protocols from large hospitals, small clinics and urban programs.

4. Develop Routine, Site-Specific Assessment and Response

Determine who will screen, how often, local referrals, and documentation. You may utilize the RPMS domestic violence exam code, tailor an EHR reminder screen, or adapt your PCC, PCC+ forms. See the National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings for more information: www.endabuse.org/health

5. Develop and Institutionalize a Staff Training Program

Train staff on the dynamics of domestic violence, the health impact of abuse on victims and their children, perpetrator issues, how to assess, intervene and document in the clinic setting, and culturally relevant resources and referral agencies in the community. Invite a local advocate to help you with the training and utilize training resources from the FVPF: www.endabuse.org/health Add DV content to new employee orientation.

6. Order/Adapt Resource Materials for Clinicians and Patients

Model materials may be easily obtained from the FVPF's National Health

Resource Center on Domestic Violence (www.endabuse.org/health), Mending the Sacred Hoop Technical Assistance Project (<http://www.msh-ta.org/>), and Sacred Circle, the National Resource Center on Ending Violence Against Native Women (<http://www.sacred-circle.com>). You may adapt the FVPF's materials by adding your logo and local DV referral; send an email to health@endabuse.org for electronic files and permission to reprint.

7. Increase Community Awareness

Participate in health fairs, pow-wows, tribal radio, television and print news segments and other community events where you can distribute materials, or send prevention and intervention messages. Paint a mural in the hospital, or hang a banner on the building with healthy families/prevention messages.

8. Integrate Domestic Violence Prevention into Wellness Programs

Integrate domestic violence prevention messages into wellness activities as part of wellness fairs, family activities and other preexisting wellness efforts.

9. Establish Quality Assurance Mechanisms to Monitor Response

Evaluate the RPMS exam code on domestic violence (see appendix 2) to measure DV assessment rates. Some sites elect to conduct chart reviews to analyze prevalence of abuse, how often assessment is taking place, and whether intervention, referral and follow-up were conducted.

10. Engage Youth, Boys and Men

Encourage men to mentor boys about relationship violence and how to respect women by hanging posters from the FVPF's "Coaching Boys into Men" campaign. Visit: www.endabuse.org/CBIM for more information.

Appendix 2

Materials to Help Prepare Your Clinical Setting

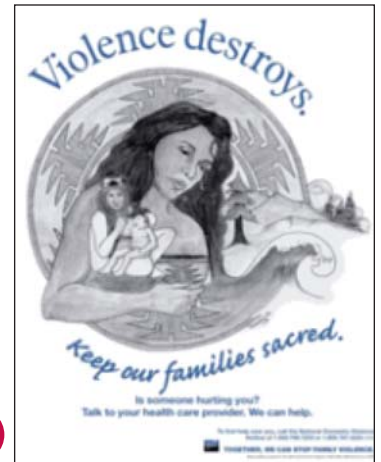
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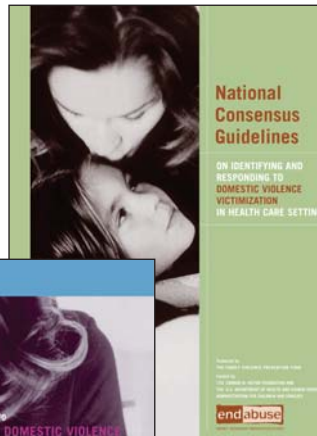
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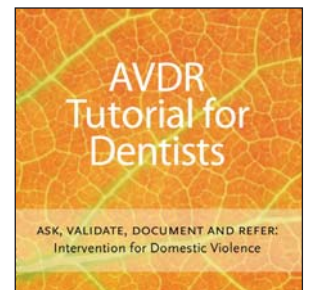
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6



9



8



7



Materials Order Form

Are you looking to start a domestic violence response program in your health setting? The Family Violence Prevention Fund offers free materials to help get you started; to view a complete catalog visit: www.endabuse.org/health

- 1. Fathering After Violence AI/AN Poster
- 2. Coaching Boys into Men AI/AN Poster
- 3. Violence Destroys, Keep our Families Sacred Poster
- 4. Violence Destroys, Keep our Families Sacred Safety Card
- 5. National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings
- 6. Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health
- 7. "Is someone hurting you? You can talk to me about it" Provider Buttons
- 8. Screen to End Abuse Training Video (32 min. on CD)
- 9. Ask, Validate, Document, Refer (AVDR) Tutorial for Dentists (15 min. on CD)

Check the materials above that you would like to receive, complete the form below and fax to: 415-252-8991 attn: Health or email: health@endabuse.org. You may also view our entire catalog, and request materials online: www.endabuse.org/health

Name: _____ Title: _____

Facility/Organization: _____

Mailing address (please provide street address and not P.O. box): _____

City, State, Zip: _____

Phone: _____ Email: _____

The FVPF moderates a listserv for more than 200 health care providers & DV/SA advocates working across Indian Country on DV/SA health system change. The list includes announcements on funding, conferences, research and tools/materials; while providing a forum for questions and best practice resource-sharing.

YES, add my email to this list! You must provide your email to the form above.
Please also add my colleagues to this email list:

Tell us about the work you're doing to help raise awareness of DV/SA and improve community and health responses. Drop a line to Anna Marjavi, Program Manager, Family Violence Prevention Fund, anna@endabuse.org . Thanks!



An Overview: The RPMS Domestic Violence Screening Exam Code and GPRA Reporting

“Recent initiatives and developments in health information technology offer the opportunity for improved documentation and data collection regarding assessment and intervention for domestic violence at the point of care. Being able to see the results of their efforts to increase screening rates through easy to generate electronic reports was very encouraging to providers.”

— Denise Grenier, MSW, LCSW, former Project Officer
IHS-ACF DV Project and Federal Lead RPMS
Behavioral Health

What are the current recommendations for screening for Domestic Violence?

Domestic Violence is a serious and common problem in the patients we serve. A 2008 CDC report on health and violence found 39% of Native women surveyed identified as victims of intimate partner violence (IPV) in their lifetime, a rate higher than any other race or ethnicity surveyed. The U.S. Department of Justice Bureau of Justice Statistics report found that American Indian/Alaska Native women are more than five times more likely to be a domestic violence homicide victim than the rest of the population. DV is associated with 8 of the 10 Leading Health Indicators for Healthy People 2010 including tobacco use, substance abuse, injury and violence, mental health, responsible sexual behavior, access to health care, immunization, overweight and obesity.

Patients appreciate DV screening in the health care setting, as long as the screening is performed confidentially in a safe environment, and in a sensitive and respectful manner. A host of professional organizations, including the American Medical Association and the American Academy of Family Physicians, endorse screening women for DV in the

clinical setting. Some courts have considered these professional recommendations to be common enough and strong enough to constitute a standard of care. JCAHO has required DV screening policies and procedures since the early 1990s, and Intimate Partner Violence/Domestic Violence (IPV/DV) has been a Government Performance and Results Act (GPRA) indicator since 2004.

What is the current GPRA clinical performance measure for DV screening?

The Government Performance and Results Act requires federal agencies to demonstrate that they are using their funds effectively toward meeting their missions. Appropriately for a healthcare organization, most IHS indicators describe clinical treatment and prevention measures. These performance

IPV/DV GPRA Clinical Performance Measure Objective: IPV/DV Screening

Standard:

- Adult females should be screened for domestic violence at a new encounter and at least annually;
- Prenatal patients should be screened once each trimester

2010 Goal

- At least 40% of female patients ages 15-40* will be screened for domestic and intimate partner violence by the year 2010

* The age range was set at 15-40 to reflect high rates of DV prevalence among that age group, however many facilities have opted to extend this range as low as 12 years old and as old as 99 years of age. While facilities may adapt the range, the GPRA performance indicator will only measure screening rates for women ages 15-40.

Appendix 3

measures are designed to improve clinical care and provide standards for quality care.

How are Domestic Violence screening results entered into RPMS?

The Resource and Patient Management System (RPMS) is the health information system for IHS. It is a suite of clinical and administrative applications designed to support the provision of integrated and comprehensive health care. Domestic violence screening is recorded as an "Exam Code" within the context of a visit in RPMS. Providers can document results of screening on the Purpose of Visit (POV) line of the RPMS Patient Care Component (PCC) Encounter Form. Included on the POV line should be the name of the exam (IPV/DV Screening), the result, and the initials of the provider who screened. A brief comment related to the screening can also be included here. If a patient declines a screen or if the provider is unable to screen (for example, if the domestic partner is in the room) this should also be documented.

Allowable results are:

(N) Negative – denies being a current or past victim of DV

(PR) Present – admits being current victim of DV

(PAP) Present and past – admits present and past victim of DV

(PA) Past – denies being a current victim, but admits being a past victim of DV

(R) Refused – patient declined exam/screen

(U) Unable to screen

RPMS Electronic Health Record

Providers can also enter results of IPV/DV screening electronically via the RPMS Electronic Health Record (EHR), or the RPMS Behavioral Health System (BHS). Direct

Clinical Reporting System IPV/DV Screening Indicator Logic

Denominators:

- 1) Female Active Clinical patients ages 15 and older at beginning of Report period.
GPR: Female Active Clinical patients ages 15-40

Numerators:

- GPR: Patients screened for or diagnosed with intimate partner (domestic) violence during the Report period, including documented refusals in past year.
- A) Patients with documented IPV/DV exam.
 - B) Patients with IPV/DV related diagnoses.
 - C) Patients provided with IPV/DV patient education or counseling.
 - D) Patients with documented refusal in past year of an IPV/DV exam or IPV/DV-related education.

Definitions:

- 1) IPV/DV Screening: PCC or BHS Exam Code 34
- 2) IPV/DV Related Diagnoses: POV, Current PCC or BHS Problem List 995.50, 995.51, 995.53, 995.54, 995.59, 995.8083, 995.85, V15.41, V15.42, V15.49; BHS Problem Code 43.*, 44.*
- 3) IPV/DV Patient Education: Patient Education codes containing "DV-" or "-DV"
- 4) IPV/DV Counseling: POV V61.11
- 5) Refusals: A) Any PCC or BHS refusal in past year with Exam Code 34, B) Any refusal in past year with Patient Education codes containing "DV-" or "-DV".

Patient List:

Women not screened and without documented refusal.

provider entry of screening results is easy, efficient and provides additional privacy of sensitive patient information. The IPV/DV

screening exam code is documented with other exams, health factors and patient education activities on the Wellness Tab in the above applications. Some providers have indicated that they believe the increase in the documented rate of IPV/DV screening at their facilities can be attributed to the ease of direct provider entry of clinical information into RPMS like the Electronic Health Record.

Additionally the EHR offers providers clinical decision support tools to facilitate routine and effective screening, referral and documentation.

Clinical Reporting System

Clinical Reporting System (CRS – formerly known as GPRA+) is the reporting tool used by the IHS Office of Planning and Evaluation to collect and report clinical performance results (GPRA measures) annually to the Department of Health and Human Services and to Congress. CRS is a software application intended to eliminate the need for manual chart audits for evaluating and reporting clinical indicators that depend on RPMS data.

The CRS logic for the domestic violence GPRA indicator is generous. Unsuccessful attempts to screen for domestic violence (recorded as “Refused” or “Unable to Screen”) are included in the logic as well as the results of completed screenings. Additionally, the logic includes domestic violence-related diagnoses (POVs) and DV-related Patient Education. Entry of any one of these items on a qualified patient for a qualified visit is considered as a positive count toward the GPRA indicator.

For further details on the IPV/DV GPRA indicator logic, CRS and GPRA, visit: <http://www.ihs.gov/cio/crs/index.asp>

IPV/ DV Health Maintenance Reminder and PCC Management Reports

The RPMS IPV/DV screening exam also has a corresponding Health Maintenance Reminder (HMR) that appears on the Health Summary. The reminder mimics the CRS logic. The



default parameters that control the display of the reminders are: females, 15 years and older, and annual screening. The display will include the “Date Last Done” and a prompt “Due Now” if a screening was not recorded in the last year. The IPV/DV Health Maintenance Reminder should be added to each type of Health Summary that includes the HMR component. To support local policy and procedures for screening (e.g. all female patients 15-40) the default parameters of the IPV/DV reminder can be changed locally by the RPMS Site Manager at the request of clinicians.

While CRS can provide aggregate data for Area and National reporting purposes, PCC Management Reports can provide a more precise view of domestic violence screening efforts at the local level. Access to the IPV/DV reports is controlled by a security key. Five different reports are available and by any specified date range can provide screening rates by gender, age, clinic, provider who screened, primary provider, and associated Purpose of Visit for the encounter in which the screening occurred. Patient lists including results of screening can also be generated to facilitate appropriate follow-up and care. Similar IPV/DV reports can also be found in the RPMS Behavioral Health System.

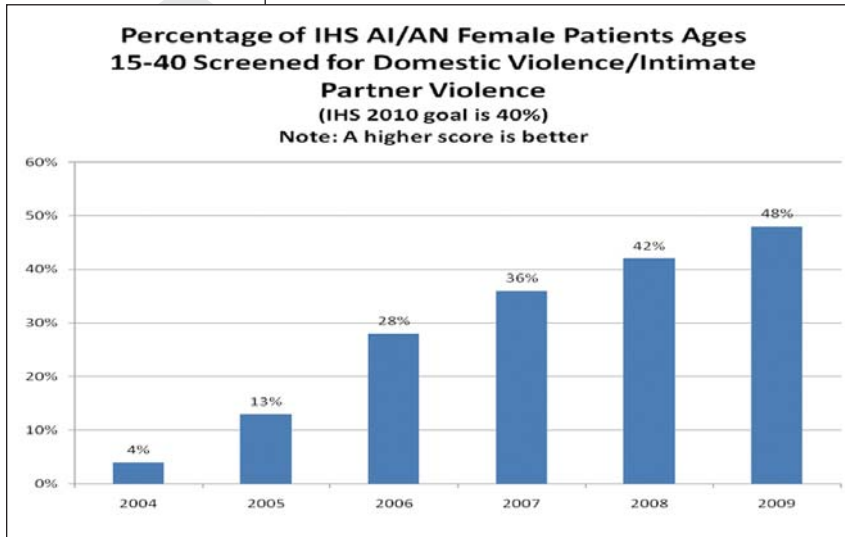
Rosebud IHS Medical
Records Staff



Appendix 3

How is IHS doing?

The IHS long-term goal is to screen 40% of female patients ages 15-40 for domestic violence by the year 2010. IHS has already exceeded this goal. The data on the graph below reveal a steady increase in screening; from 4% in 2004 to 42% in 2008.



Conclusions

As more data becomes available over time the CRS quarterly and annual reports will provide real and meaningful comparisons to past domestic violence screening efforts, allowing the Agency to accurately measure its effectiveness in achieving this very important clinical objective. In addition, the latest version of the RPMS PCC Management Reports gives providers the flexibility to design their own reports and to evaluate locally determined measures of performance. Documenting screening results is now easier in the RPMS Electronic Health Record and GPRA reporting is becoming increasingly automated. All of these efforts will contribute to the mission of improved patient care and health outcomes.

For additional information on the RPMS IPV/DV Screening Exam Code contact Denise Grenier, MSW, LCSW: Denise.Grenier@ihs.gov

Dr. Carolla, Warm Springs Health and Wellness Center

Dr. Rachel Locker and Montell Eliot, Warm Springs Health and Wellness Center



Innovations in Planned Care for the Indian Health System and Domestic Violence: FY 2008-09

The Indian Health Service has launched the second phase of a clinical quality improvement effort, Innovations in Planned Care for the Indian Health System (IPC), to improve health care delivery and health outcomes for AI/AN health care users. The IPC aims to support community and individual wellness and strength and reduce the prevalence and impact of chronic conditions – including domestic violence (DV) as a preventative health screening measure. Fourteen sites participated in the IPC I and 38 now participate in IPC. Nearly half of the 38 sites are continuing DV project sites and have been involved in reforming their site's response to DV for at least one year. Five of the IPC sites are currently funded to better address both DV and sexual assault responses. A key concept with the IPC Collaborative is change across conditions.

In all of the IPC sites, DV screening is expected to be integrated into general primary care screening of all females aged 14 and above. The DV screening will not be measured as a “stand-alone” screening, but will be bundled with other primary care screenings on BMI and blood pressure measurement, depression, tobacco, and alcohol misuse. This kind of all or none bundled measure is a tailored method of measurement using a patient-centered approach. It is of critical importance that DV/IPV screens are conducted in a private area between only the patient and provider. Because screening demands access to appropriate service delivery, positive screens on DV, depression or alcohol will require access to behavioral health services.

The GPRA 2007 target for DV/IPV screening was 28%, however the national result exceeded this target with a screening rate of 36%. IPC I surpassed the national GPRA rate with a 48% aggregate result. The 2008 aggregate results for the IPC II sites is 62% (weighted average) among 38 sites.



Aims:

1. Improve the overall health and safety of patients facing domestic violence (DV) and Intimate Partner Violence (IPV)
2. Improve the health care facility early identification and access to services for DV and IPV
3. Raise the visibility of domestic violence as a public health issue throughout American Indian/Alaska Native (AI/AN) communities.

For more information about the IPC and integration of domestic violence, contact Lisa Dolan-Branton, RN, Senior Clinical Informatics/Improvement Advisor, IHS Chronic Care Initiative, 301-443-8680, lisa.dolan@ihs.gov or visit http://www.ihs.gov/NonMedicalPrograms/DirInitiatives/index.cfm?module=fact_chronic



IHS/ACF Domestic Violence Project Faculty Biographies



Karen M. Artichoker (Oglala Lakota/Ho-Chunk) is past Director of Administration and Shelter services for Cangleska, Inc. and responsible for the administration and fund raising for this multi-level domestic violence prevention and intervention program located on the Pine Ridge Indian Reservation, SD, home of the Oglala Lakota Nation.

As a co-founder of Cangleska, Inc., she worked to develop and implement this nationally recognized project which includes two shelters, outreach advocacy, offenders' program, coordination of the tribal criminal justice response to domestic violence, domestic violence probation services, technology development and a housing/economic development project. Ms. Artichoker is also the Project Director of Sacred Circle, a project of Cangleska, Inc. which provides technical assistance, training and consultation to Indian Country on domestic violence response.

A nationally recognized advocate and visionary in domestic violence program development, Ms. Artichoker has published a variety of domestic violence materials. She is qualified as an expert witness in federal, state, and tribal court. She is the recipient of the Charles Bannerman Fellowship for community activists of color and the Marshall's Peace Prize. Cangleska, Inc. was a 1999 winner of the Ford Foundation and Harvard University's "Innovations in American Government" award.



Donald Clark, MD, MPH has been a family physician in the IHS since 1987, first in Chinle Navajo, then Jemez Pueblo and in Albuquerque. He began to address DV as a health care issue while working in the Albuquerque Service Unit's busy Urgent Care,

while simultaneously pursuing a Master's in Public Health degree. He has worked to improve the health care response to DV for 10+ years.



Theresa Ann Cullen, MD, MS is the Chief Information Officer (CIO) and Director of the Office of Information Technology for the Indian Health Service (IHS), of the Department of Health and Human Services. As CIO, Dr. Cullen oversees a diverse range of agency functions in information systems planning, development, and management. Dr. Cullen is a commissioned officer in the U.S. Public Health Service and holds the rank of Rear Admiral.



Lisa Dolan-Branton, RN, joined Indian Health Service's Office of Information Technology and Office of Clinical and Preventive Services in October '07. She

supports the IHS Director's office in Rockville, MD as the Senior Improvement Advisor supporting the Chronic Care Initiative and Innovations in Planned Care in the Indian Health System Collaborative. Lisa has 19 years experience in the US Public Health Service Commissioned Corps as a clinical nurse and program director in the primary care settings. Previously, CDR Dolan-Branton served as AHRQ's Senior Advisor for Rural and Community Health, as well as, assisting with direction of a \$60 million Health IT Portfolio. From 1997 through 2003, she worked with HRSA's Bureau of Primary Health Care-funded Community Health Centers in many clinical quality initiatives, including creating a network for clinicians caring for underserved populations, a task force working on issues in NE r/t farm workers health, and building quality health care service delivery in under-resourced health care settings. CDR Dolan-

Branton also managed a Western Hemisphere health care delivery system for NOAA during her career.



Elena Giacci (Diné) is an Anti Sexual and Domestic Violence Specialist for Native Women. Elena trains throughout North America on sexual and domestic violence issues.

Most recently she worked for Sacred Circle as a National Trainer. She is one of the Team Leaders for the National IHS/ACF Domestic Violence Project, President of the Board of Directors for Rape Crisis Center of Central New Mexico, Chair of American Indian Death Review Team, and the NM Attorney General FVPA Task Force. Elena has served as the Executive Director of the State Coalition to Stop Violence Against Native Women, co-chair of the Albuquerque Mayors Sexual Assault Task force, member of the NM Governors Victim Rights Alliance and executive member of the Coalition to Stop Violence Against Women and Children. She has 20 years experience in the Violence Against women field and has a B.A. in Criminal Justice. Elena is dedicating her time to the subject of oppression and violence against women. She attributes her knowledge in the area of advocacy to the numerous women who have honored her with their stories and friendship. Elena also is a trainer in working with media and developing media relations. For over 11 years She has produced and directed a “Stop the Violence” TV show in Albuquerque, New Mexico.

Denise Grenier, MSW, LCSW is a licensed independent clinical social worker with Indian Health Service (IHS). Ms. Grenier has provided behavioral health services on the on the Tohono O’Odham Nation in southern Arizona for over ten years. Since 2003 she has been the lead on the development of behavioral health functionality in the IHS health information system, Resource and Patient Management System (RPMS), and is the national clinical application coordinator for the RPMS Behavioral Health System. She was instrumental

in the development and deployment of clinical tools and performance measures in RPMS used to record intimate partner violence (IPV) screening activities and evaluate rates of screening. Ms. Grenier is the IHS Project Officer on the Indian Health Service – Administration for Children and Families Domestic Violence Technical Assistance Project.



Brenda Hill, (Siksika) is the Native Co-Director for the South Dakota Coalition Against Domestic Violence and Sexual Assault (SDCADVSA). Previously she was the

Education Coordinator for Sacred Circle, National Resource Center to End Violence Against Native Women for over 11 years. She has been actively involved in the SDCADVSA since 1989, including 2 years as Coordinator in the days before VAWA. She is a founding mother & former Director of the Women’s Circle Shelter Program on the Lake Traverse Reservation. Prior to Women’s Circle, she was a member of the Sisseton Wahpeton Community College faculty where she developed and taught courses for a chemical dependency degree program. Brenda earned a B.A. from New York University and an M.A. from the University of South Dakota, but attributes her expertise in the area of advocacy to the many grassroots women who have honored her with their stories and friendship, her personal experience as a survivor of domestic violence and her involvement with the SDCADVSA.



Cindy Hupke, RN, BS, MBA, Director, Institute for Healthcare Improvement (IHI), is responsible for the strategic partner relationships with the Health Resources and Services

Administration and the Indian Health Service. Both initiatives focus on transformation of health care within large systems, primarily addressing chronic disease and preventive services. Ms. Hupke is also the lead in IHI’s portfolio of work on health disparities and equity.

Appendix 5



Marylouise Kelley, PhD, is the Director of the Family Violence Prevention & Services (FVPSA) Program, U.S. Department of Health & Human Services, which supports nation-wide shelter and support services for victims of domestic violence, the National Domestic Violence Hotline, a network of National Resource Centers and culturally-specific Institutes, and discretionary domestic violence grant programs. Dr. Kelley began working in the domestic violence and sexual assault field in 1983. Her career spans working as a victim advocate in a community-based program to managing national programs addressing sexual assault, domestic violence, and child abuse. Dr. Kelley earned her doctorate in Social Work at Catholic University where she conducted research on the effects of children on domestic violence survivors' decision-making patterns.



Debbie Lee (Senior Vice President) has been with the Family Violence Prevention Fund (FVPF) since 1981 working to strengthen the health care response to domestic violence through leadership development, health education and prevention efforts, and policy reform. Her work has included the development and implementation of the U.S. DHHS funded National Health Resource Center on Domestic Violence, the 15 state National Standards Campaign and a 15 Tribe health center initiative. She was a founding board member of the Asian Women's Shelter in San Francisco, The Women's Foundation and national Asian and Pacific Islander Institute on Domestic Violence and the recipient of the first annual Helen Rodriguez-Trias 2002 Award for Excellence in Women's Health Leadership of the CA Department of Health Services.



Rachel Locker, MD is a Commander in the U.S Public Health Service and has served with Indian Health Service for 10 years since completing residency at Anderson Area Medical Center, Anderson South Carolina in

1996. In 1998 she introduced domestic violence screening as a clinical objective for the Portland area of Indian Health Services and since has developed policy and procedures regarding domestic violence screening and intervention, sexual assault examination and treatment and workplace domestic violence policies. She is coordinator of the Indian Health Service Violence Against Native Women website and a grantee in the IHS/ACF Domestic Violence Project.

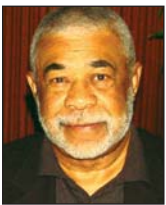


Anna Marjavi has worked with the Family Violence Prevention Fund since 1999. Since 2002 she's managed the "Indian Health Service/Administration for Children and Families Domestic Violence Project" working with more than 100 Indian, tribal and urban health care facilities and domestic violence/sexual assault advocacy programs across the U.S. Anna coordinates the National Health Resource Center on Domestic Violence; built the nationally recognized annual event, Health Cares About Domestic Violence Day; and coordinates the National Conference on Health and Domestic Violence. She also organizes health professional students on domestic violence curricular reform and developed a Teen Dating Violence information packet for use in healthcare settings. Prior to working with the FVPF, Anna worked with the Human Rights Campaign and the Alliance for Justice, and as a volunteer with Communities United Against Violence, Project Open Hand and Friends of the Urban Forest.



Jeremy NeVilles-Sorell (Ojibwe) has worked in the field of domestic violence since 1994 on issues affecting children who have experienced domestic violence, supervised visitation, batterers intervention, and providing training and education. He worked for four years coordinating the Duluth Family Visitation Center serving families with a history of domestic violence and dealing with visits and exchanges of children between

parents. Jeremy concurrently worked during that time at the Women's Transitional Housing Coalition in Duluth, Minnesota, as the Child Care Coordinator providing activities and groups for children who have witnessed violence. He joined the staff of Mending the Sacred Hoop Technical Assistance Project in 1998, a national program to assist American Indian Tribes and Alaskan Native Villages to develop responses to violence against Indian women through training and technical assistance, and became Co-Team Leader of Mending the Sacred Hoop in 2002. He has also been involved with Men As Peacemakers; a community group devoted to promoting non-violent lifestyles for men, conducted groups with teenage boys on domestic violence, and has co-facilitated groups for Native men who have battered.



William D. Riley (retired) From fiscal year (FY) 1986 to FY 2008 Mr. Riley served as the Director of the Family Violence Prevention and Services Program at the

Family and Youth Services Bureau, Administration on Children, Youth and Families: US Department of Health and Human Services. Mr. Riley administered three national domestic violence formula grant programs: Family Violence Prevention Grants to State Agencies for Battered Women's Shelters; Family Violence Prevention Grants to State Domestic Violence Coalitions; and Family Violence Prevention Grants for Battered Women Shelters Native to American Tribes and Alaskan Native Villages. During fiscal year (FY) 2007, \$101 million was made available for the three domestic violence formula grant programs.

In addition to administering the family violence formula grant programs, Mr. Riley served as administrator for national domestic violence organizations providing services to underserved communities. Direction and guidance were provided to the Institute on Domestic Violence in the African American Community; the Asian and Pacific Islander Community on Domestic Violence; the

National Latino Alliance for the Elimination of Domestic Violence; and the Sacred Circle – the National Resource Center to End Violence Against Native American Women. Mr. Riley administered funding and provided direction for the National Domestic Violence Resource Center Network (DVRN). To raise a greater awareness of domestic violence across the nation, Mr. Riley spearheaded efforts with the United States Postal Service to launch the Stop Domestic Violence Postal Stamp in October 2003, providing more than \$3 million in funds.



Rose Weahkee, PhD (Diné) is a Clinical Psychologist and the Director for the Indian Health Service (IHS) Headquarters Division of Behavioral Health (DBH) in

the Office of Clinical and Preventive Services. Prior to her current position, she served as the Acting Deputy Director and Public Health Advisor for the IHS Headquarters DBH and the Behavioral Health Consultant for the California Area IHS. She also served as the Administrative Clinical Director for United American Indian Involvement, Inc., which was an IHS/ACF Domestic Violence Project participating site from 2004 through 2008. Dr. Weahkee has served on numerous boards at the local, state, and federal level advocating on behalf of American Indian and Alaska Native issues. She has been involved in administration, program development, research, teaching, and direct services. She has presented and published on numerous behavioral health-related topics including a chapter addressing issues facing Native women who are survivors of violence in urban communities. She also directs the IHS Domestic Violence Prevention Initiative. The purpose of this initiative is to support a national effort by the IHS to address domestic violence and sexual assault within American Indian and Alaska Native communities. Dr. Weahkee was the recipient of the American Psychological Association Early Career Award in the Public Interest in 2006.

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National Domestic Violence Resource Centers

**Battered Women's Justice Project
Criminal Center**
800-903-0111 ext. 1
www.bwjp.org

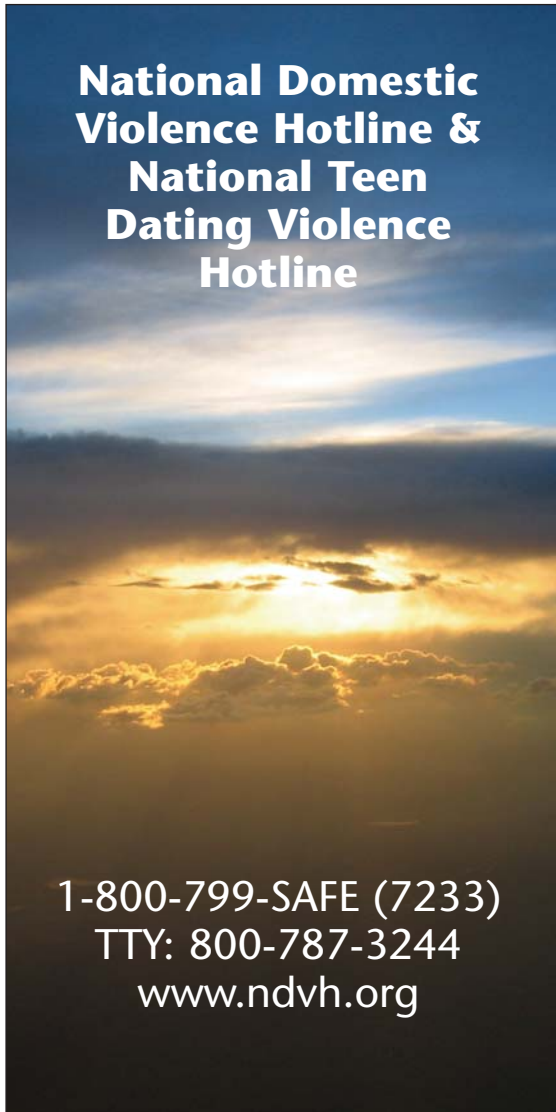
**Battered Women's Justice Project
Civil Center**
800-903-0111 ext. 2
www.bwjp.org

**Battered Women's Justice Project
Self-Defense Center**
800-903-0111 ext. 3
www.bwjp.org

**Health Resource Center on
Domestic Violence (FVPF)**
888-792-2873
www.endabuse.org/health

**Mending the Sacred Hoop Technical
Assistance Project**
202 East Superior Street
Duluth, MN 55802
(888) 305-1650 · (218) 623-HOOP
Fax: (218) 722-5775
<http://www.msh-ta.org>

**Sacred Circle: National Resource
Center to End Violence Against
Native Women**
877-733-7623
www.sacred-circle.com



**National Domestic
Violence Hotline &
National Teen
Dating Violence
Hotline**

1-800-799-SAFE (7233)
TTY: 800-787-3244
www.ndvh.org

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Cheyenne IHS mural



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- ⁷ Eileen Hudon has been a long time advocate and activist working across Indian Country on domestic and sexual violence.
- ⁸ Debbie Lee has been working on health care's response to domestic violence since 1981 and directed the FVPF's National Health Initiative until 2008 when she became a Senior Vice President for the FVPF and the Deputy Director for the National Program Office, Start Strong: Building Healthy Teen Relationships.
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IHS/ACF DV Project participants and faculty convened for training and education in Minneapolis, MN (June, 2008).

Thank you.

Thank you to the project's funders, faculty, site leaders and participants who devoted their time and creativity to further our commitment to end domestic violence across Indian Country and return to what is traditional: to respect, honor and nurture all our relatives.

To view this Report as a PDF, or to order hard copies, visit www.endabuse.org/health.
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