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Everyone Deserves to be Safe

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FRAGILE: Handle With Care

An AFS Newsletter on Domestic Violence

AFS Partners and DHS Sister Agencies Continue Efforts to Impact Domestic Violence

As most everyone knows by this time, a reorganized Department of Human Services Will soon become a reality. The plan for reorganization consolidates the work of six separate DHS divisions and three program offices into one Field Operations group supported by three integrated support groups: Program and Policy; Administrative Services; and a Continuous Systems Improvement group. This comprehensive reorganization will be built on a new vision for human services which has emerged from the increasingly collaborative work DHS and its partners have been doing in many local communities of the state. The purpose of the reorganization is to provide better service to clients. The reorganized DHS will be a unified department where an individual, a household, or a family will be assisted by a lead services manager and a team of specialists as required, rather than by one or more separate divisions and multiple caseworkers and case plans. This new model is intended to provide a greater level of safety and protection to anyone who is in an abusive relationship. If passed by this Legislature, House Bill 2294 will eliminate the current names and administrative structures of the DHS divisions. Even if this bill is not passed, it is clear that the Department's vision for better client service will continue to be implemented incrementally through wider application of the collaborative model and one-stop concept throughout the state. This issue of the newsletter (and possibly the next) will take a look at what some other DHS divisions and partners have to tell us and what they are currently doing for survivors of domestic violence. The first in this series is

from the Oregon Health Department and was provided by Aimee Santos, Women's Health Educator. Also included is a report from Joie Stover on a collaborative project initiated by the Division of Child Support.

Intimate Partner Violence: A Public Health Concern

Increasingly through the years, the public health sector has begun to recognize its responsibility in reducing intimate partner violence. It has invested much of its resources in investigating trends and incidence rates, profiles and circumstances, programs and best practices. Data available to us shows that intimate partner violence is exceedingly prevalent, studies showing that 25% (approximately 12 million) of women in the United States will be abused sometime in their lives, becoming the most common cause of nonfatal injury to American women. (Oregon Health Division (2000) Preventing Intimate Partner violence, p.6). In Oregon, where incidence rates mirror national trends, more than 1 of every 8 women 18 to 64 years of age will be victims of intimate partner violence. Yet it is also becoming increasingly clear that victims are not seeking support from sources that would be most helpful to them. A greater proportion of victims (80%) disclose their experiences of abuse to family or friends while only 32 - 35% report to police, mental health providers, or their work supervisors. A mere 11% of victims will go to victims' programs or domestic violence shelters which are likely to be the most supportive and responsive to their needs. (Glick, B., & Johnson, S., Pham, C., (1999) Oregon Health Division and Multnomah County Health Department, 1998 Oregon Domestic Violence

Needs Assessment: A Report to the Oregon Governor's Council on Domestic Violence) Understandably, there are many barriers to reporting and seeking assistance. Shame, emotional and financial dependence on the abuser, fear for their safety, denial of the abuse, cultural and community pressures to keep the family intact, are only some of the complex factors that inhibit disclosure.

In this context, health care settings often provide a safe haven and respite from the violence. They provide strategic and programmatic opportunities to reach out to possible victims of abuse. Asking clients about safety issues, screening for abuse, providing support, making referrals and sensitive documentation of experiences of violence have all been identified as appropriate health care responses to the issue. Ignored, the health consequences of domestic violence are dire. Various studies have shown correlations between partner abuse and significantly poor physical and mental health. Notable health outcomes are high prevalence of substance abuse in patients, increased predisposition to suicide and homicide, acute physical injuries, greater possibility of having unintended pregnancies, association with gynecological problems, and worsening mental health as seen in higher reports of depression, anxiety, somatization, and posttraumatic stress disorder. In addition, investigations have shown that health care utilization and costs are greater for victims of partner violence. One major health plan in Minnesota reported an additional amount of \$1,175 was spent annually on female victims of intimate partner violence compared with female nonvictims. (Kimberg, Leigh. Addressing Intimate Partner Violence in Primary Care Practice, Medscape Women's Health 2002; 6(1): 3-5. <http://Iwomenshealth.medscape.com>)

The Oregon Health Division has heeded this clarion call in a variety of ways. It has sought to integrate these concerns as it responds to the myriad health needs of the community; mostly through the three functions of public health: assessment, policy-making and assurance of services. The division participated in a statewide needs assessment of victims and DV programs which has resulted in two major outputs: a report to the Oregon Governor's Council on Domestic Violence and a guidebook for public health people to use in program design and evaluation. Efforts are also underway to build a trauma registry as one way of building data systems for monitoring and responding to violence against women. Eventually, we hope to build a greater

understanding of the dynamics of domestic violence within our staff and have them gain an appreciation of how these issues impact on our clients' abilities and use of health care services. To facilitate this, the OHD Women's Reproductive Health Section has begun to establish a network of DV contact persons in each county health department, similar to the network instituted in AFS. Hopefully, this network will serve as a venue for the exchange of informa-

tion, innovative practices and strategies, tools and other resources. We then hope to pay great attention to developing our staff and partners' skills in protocol-development, interviewing, intervention, and documentation. What must also not be forgotten is our dedication to establishing and strengthening community partnerships - learning from their experiences and building from their needs.

The problem of intimate partner violence is complex and its repercussions, health and otherwise, vast and grave. It can only be eliminated through coordinated and concerted efforts of the community and its partners. The Oregon Health Division strives to be that public health partner and it hopes to serve as a valuable resource to different populations and to the health care community in general.

The Women's Reproductive Health Section of OHD has produced brochures with information on domestic violence, safety planning and community resources, listing all the domestic violence crisis lines state- wide. Interested parties are welcome to print copies of this off our website - www.ohd.state.or.us/whidviabuseinfo.htm



DCS Backpack Project

Since April was National Child Abuse Awareness Month, the Division of Child Support Domestic Violence Committee, in collaboration with AFS and SCF, successfully coordinated a statewide backpack drive to provide new backpacks to children who are going into foster care. The new backpacks will be given to SCF for distribution throughout the state.

It isn't unusual for children moving into foster care to arrive with their belongings transported in plastic garbage bags. This project was undertaken in the belief that the move itself is traumatic enough, but that making the move in this fashion sends the children a questionable message and one which may be corrosive to self-esteem. Even though they may be coming out of personal chaos and into unfamiliar surroundings, if they can receive a new backpack for their personal items, they may develop or preserve a more positive image of themselves. This project is also intended as a tangible demonstration to these children that business leaders and other members of their community value them and care how they're doing. There are currently over 6,000 children receiving foster care services in the state of Oregon, according to Robert Crawford, SCF Administration. If you were wondering, this project does relate to domestic violence. SCF tells us that domestic violence is also present in about one quarter of the families where child abuse results in the decision to recommend foster care, although domestic violence is not the primary reason for removal of the child.

Donations were received from the following merchants: Bi-Mart Corporation, Factory 2-U Stores, Fred Meyer in Redmond, Mervyn's of California in Medford and Clackamas, and Target Stores in Bend. In conjunction with this effort, DCS, SCF, and AFS sponsored fund raising events at many of their work sites. In all, 181 new backpacks/carry bags were donated and an additional \$1,725 in cash and gift certificates. Money collected from these events will be used to purchase additional backpacks to be distributed proportionately among the thirty-eight SCF branches.

This project was spearheaded by Joie Stover, Division of Child Support, Medford. The DCS committee members included Doug Miller, Portland; Tami Motiff, Roseburg; and Chris Reafleng, Eugene. This project would not have been possible without the support received from Cheri Breitenstein, Carol Krager and participating AFS staff. We congratulate and thank everyone who supported this first state-wide collaborative effort.

A New Application For AFS Benefits

As of June 1st AFS began using a new application and a new application process. The goal of the new application process is to reduce paperwork for applicants and improve customer service. People applying for Food Stamps, Emergency Assistance and Temporary Assistance for Domestic Violence Survivors (TA-DYS) will only need to complete a two-page application. TA-DYS applicants will then be given the option of being interviewed that same day or they can choose to have an appointment for an initial safety assessment within 8 working hours. The person screening applications will ask some additional questions that were previously on the

eight-page application. People applying for Temporary Assistance for Needy Families (TANF) and medical benefits will complete two pages of additional questions that relate directly to program eligibility for those programs. As part of the new process, screening instruments were developed, including screening protocols for domestic violence. The domestic violence screening protocols were reviewed by a domestic violence service provider to ensure that they address any potential safety concerns during the application process.

If you'd like to see what these new screening protocols look like, they will be in the AFS on-line Family Services Manual as of July 1, 2001. Or you can give me a call (503-945-6094) or e-mail sherwin.c.cullison@state.or.us and I'll get a copy to you.



QUIZ

- Because her job may represent her only independence from her batterer, the last thing a battered woman needs is to lose her job. However,
 - 10%;
 - 20%;
 - 30%;
 - 40%
 of abused women report having lost a job because of harassment at work by their abuser.
- Each year in the United States, 1.5 million women seek emergency room care for physical abuse. The average cost per woman is
 - \$550;
 - \$850;
 - \$1,075;
 - \$1,633.
- The first state to mandate that all hospitals and licensed clinics routinely screen patients for the presence of violence, document it and use

domestic violence referral lists was

- (a) Oregon;
- (b) Minnesota;
- (c) California;
- (d) New York.

4. Battered women seek medical attention as a result of domestic violence more often

- (a) before separation from the abuser;
- (b) after separation from the abuser;
- (c) when young children are involved;
- (d) none of the above

5. It is estimated that

- (a) 15 percent;
- (b) 25 percent;
- (c) 40 percent;
- (d) 50 percent;

of workplace problems such as absenteeism, lower productivity, turnover, and excessive use of medical benefits are due to domestic violence.

Answers:

(Highlight inside the box below)
