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# From Response to Resilience: Understanding Domestic Violence Survivors' Needs and Strategies That Could Support Them

## INTRODUCTION

Domestic violence (DV) is widely prevalent and associated with a range of adverse health outcomes as well as elevated health care costs.<sup>1,2,3,4,5,6,7,8,9,10</sup> According to the Centers for Disease Control and Prevention's nationally representative survey, one in four women and one in ten men will experience physical or sexual violence, or stalking by an intimate partner over their lifetime.<sup>11</sup> Today, DV is increasingly recognized as a social determinant of health that is intimately connected with other social issues, such as housing instability and economic insecurity.<sup>12,13,14</sup> Exposure to DV is also recognized as an adverse childhood experience that affects health, developmental, and social outcomes across the life course, including increased risk for adult victimization and perpetration.<sup>15,16</sup>

As the experience of DV is deeply entwined with other social issues, DV survivors often have to navigate services provided by different sectors to find safety. This may include seeking help from DV providers, shelters, law enforcement, health care, and social services, to name a few. Ending the intergenerational cycle of DV will require collaboration and a well-coordinated response across a wide network of sectors. **There are many opportunities to respond to the needs of survivors and their families—from early response to supporting recovery, and, ultimately, building resilience.** With the right policies, practices, and commitment to capacity building, providers working across sectors can better identify these opportunities and support survivors in their journeys to safety and healing.

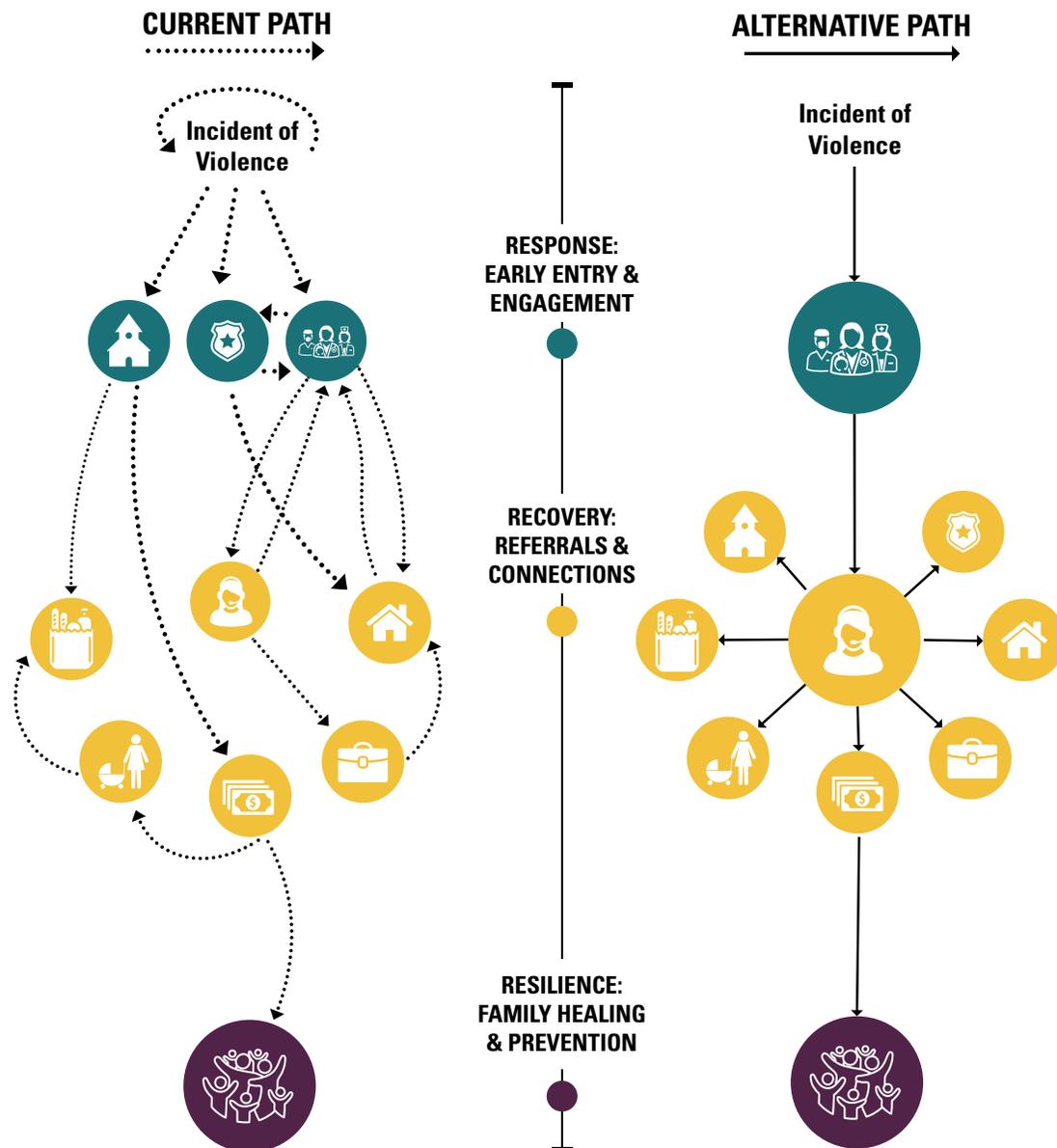
This brief highlights findings from research with California DV survivors regarding systems changes necessary to better support survivors through their journeys. Recommendations follow for opportunities in the form of policies, strategies, and practices for health care stakeholders—such as leaders, policy makers, and philanthropy—to consider as a way to strengthen provider response, lessen harm, enable safety, and strengthen families. In 2018–2019, in collaboration with DV service providers and Futures Without Violence, JSI researchers conducted in-depth interviews with survivors to better understand three areas: 1) survivors' experiences navigating services provided by different sectors; 2) survivors' unique needs, aspirations, and challenges; and 3) survivors' suggestions for program and policy changes.

# UNDERSTANDING THE JOURNEY: What Survivors Value and What They Want Most

This section summarizes aspects of survivors’ help-seeking experiences that they valued most and their recommendations for changes. Each survivor experiences a unique journey to safety and recovery, and to start building resilience. Some of the survivors who participated in this research had reached safer circumstances and begun a healing process, while others remained in violent relationships. Regardless, when survivors sought help, most described a circuitous journey that required navigating a network of services that often felt disjointed.

The left side of Figure 1 depicts this circuitous journey. Survivors move through different pathways to find safety and help. The reality, of course, is much worse than what any visual can illustrate, especially the extensive time, energy, and trauma experienced along the way. Building on survivor insights regarding what they valued most, as well as their recommendations for change, the right side of Figure 1 depicts an alternative and potentially more direct pathway to safety and healing—one that entails collaboration and a well-coordinated response across a wide network of sectors, including health care, community-based organizations, and social service providers.

**Figure 1: Mapping Survivors’ Journeys**



## RESPONSE

For many survivors who sought help, the first step was disclosure and navigating the consequent **response** from the network of available service providers. The research with survivors shows that health care providers can play a key role in ensuring that survivors receive an adequate response.

### Health care providers are critical for disclosure and could serve as gateways to other services.



Consistent with existing evidence, survivors who participated in this research reported that help seeking was a last resort. Yet, when they decided to talk about their experience of DV and seek formal help, it was often in the presence of a health care professional. Importantly, disclosure was largely dependent on having a trusted and long-standing relationship with a provider; consistent conversations about safety; and a perceived sense of “sincere concern” on the part of providers for their patients’ safety and well-being. Several survivors explained that due to trusted relationships, their providers seemed to understand the complexity of their lives and could often discern suspicious injuries or changes in their presentation. This familiarity prompted providers to probe deeply about their patient’s safety and wellness, which, in turn, encouraged disclosure.

Survivors who disclosed DV experiences to health care providers also reported being subsequently connected by their providers to other services, such as DV advocates, counselors, shelters, and DV programs. Some survivors explained that they originally viewed law enforcement as the only recourse for DV, which was a huge deterrent to help seeking. Individuals who disclosed to health care providers valued their support in connecting to services other than law enforcement. Several survivors noted that they would have left abusive relationships sooner had they known about the range of services available to them and that health care providers could facilitate a connection to these services. In general, survivors wished for more messaging around health care’s role in prevention and connection to services.

Survivors’ perspectives suggest that universal education using trauma-informed approaches, which involves prioritizing trust and relationship building over meeting screening requirements, can be key in encouraging disclosure. Furthermore, since most individuals interact somewhat regularly with health care, regardless of DV risk or experience, health care providers who establish trusting relationships with their patients could serve as gateways for survivors to a network of DV services.

## RECOVERY

After the initial response, survivors required support in accessing a wide range of services to meet their families’ needs, and begin **recovering** from the trauma. The research showed that case navigators and services that empower survivors were essential to this recovery.

*"The relationship that I built with my provider started with little things. At first, I just said I was feeling stressed and depressed. And I guess she noticed all my difficulties in not being stable, moving constantly, trying to deal with health and my sugars. I gradually started to tell her what was going on."*

*"When I noticed that my doctor really was concerned about my health, it wasn't just, okay, I'm just a number but that she was really genuinely concerned about my health ...she was like 'I just want to really know how it is you are feeling, you know, how is you doing on the inside of you.' I cried when she asked me that because nobody has ever asked that. Nobody outside of my children has ever seemed like they really cared what I was going through. I told her everything. I said 'it's embarrassing because I stayed for so long, because I didn't know what else to do.' Then I talked to her about it, told her about all that was going on."*

*-Survivor*



## Case navigators are the glue in an otherwise complex and arduous journey.

"Even if I didn't know these people, for one particular person to stay with me through this whole experience was huge. I'm trying to get past the mental and physical part of this and for me to have to use energy to figure out all this paperwork, the services, it was just not a thing that I could do at the time. So to have someone there that, even if they didn't know, and believe me there were some things they didn't know and that was okay. For them to say, 'Hey, I don't know, but I'm going to find out.' Really do that, really follow through, was huge."

-Survivor

DV survivors rarely experienced an integrated and coordinated response when seeking help. Survivors described how the process of attempting to connect with different services — often all at once — was confusing and stressful, largely due to the complexity of all the processes. Survivors noted a lack of consistency in paperwork, protocols, and messaging across sectors. Others talked about the challenges of simultaneously dealing with the trauma of DV and navigating complex systems.

Establishing connections and accessing services, such as stable housing, a job, or financial assistance, are key to recovery and the quest for a new life. In such situations, the presence of a single point person—for example, an efficient and trustworthy patient navigator in a health care setting or a case manager at a domestic violence program—can greatly improve a survivor's experience.

A few survivors reported receiving support from a single point person and reflected positively on their experience. They described how case navigators were invaluable, providing customized care, helping them identify available resources, making inquiries on their behalf, facilitating connections, and providing step-by-step guidance throughout the recovery process. This was especially important to survivors since they were not in the right physical, emotional, or psychological state to seek services independently. Overall, survivors' perspectives suggest that effective DV case management requires a cadre of staff with appropriate training and attitudes— not necessarily individuals who have all the answers, but those who provide trauma-informed care with a 'can-do' and problem solving mindset.

## Services rooted in survivor empowerment are effective and have lasting effects.

After leaving an abusive relationship, survivors faced considerable challenges to regaining independence and security. Many survivors recalled leaving their abusive relationships hastily and with little to none of their belongings. Many lost important documentation and resources, such as birth certificates, social security cards, and driver's licenses, on top of losing other essential belongings (e.g., clothing, food, and shelter for themselves and their children).

This loss was demoralizing for many survivors and, as such, they highly valued services that helped them feel empowered again. The importance of services that made survivors feel empowered was a common theme when they discussed their shelter experiences. Shelters play a critical role in survivors' journeys because they provide a temporary home base that survivors use while they recover from the trauma, connect with other services, and re-establish their lives. Seemingly small gestures were often cited as incredibly helpful to recovery. Examples include having a key to their rooms, flexible hours, and being able to renegotiate length-of-stay based on individual circumstances. While many survivors acknowledged the reasons for strict curfews and tight timelines for securing their own housing (e.g., safety concerns, resource

"I feel like for me, for the individual I am, I value independence... My husband kept everything, he took my ID, he took my phone, everything. I was left with my flip flops and the clothing I had on. That's how I went to [the courthouse]...When I got the envelope my birth certificate, I wanted to cry because I felt I was getting my life back, like someone was saying, 'Here's your life. Here's your identity.'"

-Survivor

constraints, motivation for survivors), they emphasized how healing from the trauma of DV makes adhering to strict regulations challenging and potentially re-traumatizing. Overall, survivors' perspectives suggest a need for client-centered services that balance safety with empowerment and independence.

## RESILIENCE

DV affects entire families, and the consequent trauma can span across multiple generations. To end the intergenerational cycle of violence, systems change is needed to support healing and **resilience-building** through individual- and family-focused strategies.

### Family-focused approaches are both a necessity and can help promote resilience.



Annually, 15 million children are exposed to DV in the United States.<sup>17</sup> Childhood exposure to DV is linked to adverse developmental, social-emotional, and cognitive outcomes across the life course.<sup>18,19</sup> Children exposed to DV are 15 times more likely to be physically and/or sexually assaulted, and they can experience a range of negative health, educational, and social outcomes. While health care providers tend to screen patients for DV individually, the trauma from experiencing or witnessing abuse affects the entire family. As such, there may be unique opportunities to support the entire family by identifying and addressing trauma in children.<sup>20</sup>

Many survivors who participated in this research had young children who witnessed or experienced abuse. Many survivors left their homes with their children and described navigating help at shelters as a family unit. Yet, few could recount being offered child-specific services, such as trauma-informed counseling or support with parenting and early child development. The few survivors who did receive counseling for their children, either because they were bold enough to request it or because a concerned provider offered the resource, found the support invaluable.

On a more practical level, survivors consistently noted the absence of childcare at shelters. They described facing many difficulties performing core tasks, such as finding permanent housing or securing a job, with no place to leave their children. Providing free or subsidized childcare at shelters, or ensuring survivors with families are connected to childcare, can improve the process of recovery.

Overall, these experiences indicate missed opportunities to meet basic childcare needs, identify and respond to trauma among children, and strengthen families. Individual and family-level strategies, such as mental health interventions, reducing parents' stress, supporting child development, and equipping parents with the knowledge and skills to address children's social-emotional needs and behavioral problems can be key to promoting healing and resilience for the family.

"In some shelters, especially for domestic violence, they're like, 'You can't come out at this time,' or, 'You can't give out this address,' or, 'You can't hang out around here.' They tell you not to get picked up in front of the house because they want to keep the address confidential. That's the kind of stuff that I don't like. I don't like to feel like a little kid or in prison and stuff like a criminal. To me, independence and flexibility and trust are very valuable to me. I like feeling like the people that I'm with, working with or living with, they trust me. That's really important."

-Survivor

"My son, he's seen the abuse that I received from my abuser, and the DV agency was asking did I think he needed a counselor or anything. It was just reassuring that, even with me going through it, that they were able to have a little sensitivity as far as the child, too. Because children are victims as well, when it comes to domestic violence."

-Survivor

"Things that I'd like to change, I would like to have somebody there even to help out. Like when I did therapy, there wasn't even anybody there to watch the kids. So I had to be like, 'Go play in the playroom,' and I would try to focus. Or the classes, once in a while there'd be a volunteer, but really it was like chaos."

-Survivor

## STREAMLINING THE JOURNEY: Strategies to Better Support Survivors

### Strategies to Better Support Survivors:

- » Implement a universal education approach to trauma screening
- » Create reimbursement mechanisms for traditionally non-billable providers and community partners
- » Train providers to offer trauma-informed care via telehealth
- » Encourage health plan investments in community health initiatives
- » Establish community funding pools that reinforce networks of already-available community services
- » Leverage existing programs and partnerships for earlier identification, assessment and referral

Improving survivors' journeys and experiences requires a well-coordinated and comprehensive approach involving multiple sectors. Building on survivors' suggestions discussed above, this section outlines a set of policy, program, and practice change strategies for health care leaders, policy makers, and health and well-being-focused philanthropy to consider in order to strengthen provider response, lessen harm, foster safety, and disrupt the cycle of violence. The intent of this focus is not to suggest that other sectors do not have an important role to play in supporting survivors; on the contrary, the coordination and collaboration across sectors is critical to best supporting survivors. However, given the health care focus of the body of work that this research project falls under, and the high likelihood of individuals engaging with health care during their lifetime, we emphasize health care specific opportunities that may help to strengthen future and current efforts to prevent and mitigate violence.

### Implement a Universal Education Approach to Trauma Screening

In January 2020, the California Department of Health Care Services (DHCS) began reimbursing Medi-Cal providers for screening children and adults for traumatic events or adverse childhood experiences (ACEs). Though an important milestone for the trauma/violence prevention field, given the stigma associated with such events, providers may face similar challenges in screening for trauma as when screening for DV,<sup>21</sup> and screening may not yield the desired disclosure rates (screening for DV in clinical settings is low, ranging from 1% to 14%).<sup>22,23,24,25,26</sup>

What is the solution? How can we leverage this policy opportunity for earlier identification, assessment, and connection to much needed services? **One option may be to invest in a trauma screening approach that includes universal education, particularly among pediatricians who are uniquely positioned to serve entire families.** A universal education approach entails training medical providers and all staff in a health setting on the impact of trauma on health outcomes, and promoting team-based care. Under this model, providers are encouraged to offer brief education to all patients about the connection between trauma and health. Providers are further encouraged to provide health promotion strategies and resources for peer-to-peer learning opportunities that patients can use for themselves or friends and family—regardless of their readiness to disclose abuse.<sup>27</sup> Universal education allows providers and staff to develop respectful and trusting relationships with patients, normalize conversations about trauma and violence, and mitigate the stigma associated with discussing these issues.

## Create Reimbursement Mechanisms for Traditionally Non-Billable Providers and Community Partners

While screening and identification is an important first step, a post-diagnosis plan is also important. Medical providers seldom feel fully equipped or knowledgeable about existing resources to offer their patients after they complete screenings, which can influence their willingness to screen.<sup>28,29,30</sup>

Staff or community partners that are deeply attuned to community services and who can connect patients with these services are important team members for the health care system to engage. These partners, such as patient navigators embedded in the health care system or case managers active in community settings, play an integral role within health care teams and offer the support patients need to access resources and assistance outside of the health care sector. While health care leadership readily acknowledges the connection between social issues and health outcomes, there are few reimbursement mechanisms to engage case managers and/or to help build partnerships with community-based organizations already addressing social needs. In California, Medi-Cal has historically not reimbursed managed care plans (MCPs) for these types of services, limiting health payers' willingness and ability to integrate non-medical providers into health care teams. DHCS could give plans the authority to pay for these types of providers through Medi-Cal or provide a criteria for allowable health plan investments to connect patients to available social services—such as through partnerships with community organizations.

**Creating Medi-Cal reimbursement mechanisms that enable MCPs and other medical entities to pay for traditionally non-billable providers and community partners could be critical in ensuring that, once identified, survivors and their families have opportunities to safety and reduced harm.**

## Train Providers to Offer Trauma-Informed Care via Telehealth

In response to the coronavirus pandemic, health care has rapidly adopted and expanded telehealth services to meet patient needs. Several important federal and state policies have been implemented to support health care's efforts to meet patient needs virtually. For example, in California, Medi-Cal MCPs are now required to pay for telehealth services at the same rate as in-person visits. DHCS has also waived various long-standing requirements around telehealth and telephone use for Federally Qualified Health Centers, Rural Health Centers, and Tribal Clinics.<sup>31</sup> Many of these policy changes, especially those around telehealth, are likely here to stay, making it all the more important to ensure that virtual care delivery meets the needs of the most vulnerable.

One important area to consider is screening for violence and trauma. The news and emerging evidence suggests that the coronavirus pandemic has been an incredibly traumatizing event, contributing to an increase in domestic violence rates and the need for behavioral health and social services.<sup>32,33</sup> As described above, research shows that screening for these deeply personal

and traumatic issues in the absence of a trauma-informed approach, such as universal education described above, yields low disclosure rates. In addition to the challenges of screening in person, virtual screening is likely to have its own unique barriers, such as maintaining patient privacy when screening by telephone or computer, and making warm handoffs to other virtual or in-person services.

**To better meet the needs of individuals in these situations, health care leaders, policy makers, and philanthropy could play a role by investing resources into building provider capacity to offer trauma-informed care through virtual platforms.** Several tools exist to support such capacity building; for example, Futures Without Violence has created COVID-19 response resources for medical providers, including a [tool outlining clinical pathways](#) for addressing violence during a telehealth visit. Telehealth is likely to remain a care delivery mechanism beyond the pandemic. Investing in provider training now may strengthen California's response to the growing rates of violence and trauma in the near and long term.

## Encourage Health Plan Investments in Community Health Initiatives

The implementation of the Affordable Care Act and the subsequent expansion of Medi-Cal enabled many MCPs to grow the size of their reserves. MCPs possess the flexibility to determine how to allocate these reserves, and, in recognizing the role of social needs in members' health outcomes, various MCPs have used their reserves to fund initiatives focused on social determinants of health. For example, some MCPs have established grantmaking mechanisms to support local organizations that serve their members, such as LA Care's Community Health Investment Fund that provided \$6 million in funding to programs and services addressing social determinants of health, including violence exposure.<sup>34</sup> However, with limited guidance on how best to spend these reserves, there have been instances of limited returns on health outcomes, discouraging MCPs from continuing these practices.<sup>35</sup> **DHCS could require MCPs to invest a portion of reserves in community health initiatives focused on social determinants of health, and specifically, violence prevention.** For example, the state of Arizona requires its Regional Behavioral Health Authorities (RBHAs) to reinvest six percent of their profits into community efforts, such as community-based organizations, food banks, or directly to housing.<sup>36</sup> While Arizona's requirement of RBHAs focuses on addressing the social needs of its Medicaid beneficiaries with serious mental illness, the state of California can consider a similar approach for its Medi-Cal MCPs to address other social needs and different populations, such as survivors of violence. Providing clear guidance around the use of reserves may increase the funding available to service providers who support survivors and their families in achieving safety.

## Establish Community Funding Pools that Reinforce Networks of Already-Available Community Services

A host of community-based organizations provide resources and support to survivors and their families, but often require additional financial support to

sustain their practices. Flexible funding pools are a promising approach to reinforce these efforts. Different flexible funding pools have been established throughout the country to address housing needs and provide community organizations with access to financial resources to directly address client needs. Unrestricted funding could be especially helpful during the time of the COVID-19 pandemic and for organizations that work in areas where health care investments in community efforts are more limited. For example, in 2019, Santa Clara County approved a \$5 million gender-based violence reserve for the 2019-2020 fiscal year.<sup>37,38</sup> This reserve would offer much-needed funding to local organizations that work with survivors and their families. **Philanthropy focused on advancing health care and violence prevention could encourage the creation of flexible funding pools for violence prevention with seed funding and the convening of community partners to participate and contribute.** A flexible community funding pool focused on violence prevention would give community-based organizations more discretion and flexible funding to respond to clients' needs in a timely manner.

## **Leverage Existing Programs and Partnerships for Earlier Identification, Assessment, and Referral**

Existing family-centered programs, often operated by county health systems, may provide opportunities for greater integration of DV services. Home visiting programs are one example. Home visiting provides new and expectant parents with health information, positive parenting skills, and referrals to community resources and services to promote maternal and child health, home safety, food security, and positive parenting.<sup>39</sup> Similarly, early childhood development programs can serve as referral hubs for survivors and parents at-risk of experiencing violence who may not disclose to health care providers. For example, programs such as Head Start often cultivate community partnerships, train staff to identify DV, and support parents in connecting to necessary resources.<sup>40</sup> Survivors often do not feel comfortable disclosing to health care providers or police until the violence becomes unbearable. Home visitation and early childhood development programs, which specialize in developing close relationships with families, are well suited to identify DV earlier and connect survivors to resources sooner. **Investment in existing programs and promoting partnerships, for example, between DV providers, child welfare, educators, and community leaders, are essential to mitigating and breaking the cycle of violence.**

## **CONCLUSION**

Seeking help, regaining safety and stability, and healing after experiencing domestic violence is challenging and complicated. The negative effects of DV are far-reaching and require survivors and their families to engage with many providers spanning multiple sectors. Understanding and prioritizing domestic violence survivors' unique needs can be key to strengthen California's approach to DV/trauma prevention and mitigation now and in the future.

## ABOUT THIS RESEARCH

Since 2015, John Snow, Inc. (JSI) has worked with Blue Shield of California Foundation (BSCF) and California domestic violence prevention collaboratives engaging in the question of how to design, test, and scale multi-sector strategies for DV prevention and mitigation. As part of this work, between October 2018 and February 2019, the two authors conducted 17 in-depth, semi-structured interviews with survivors to understand their experience seeking help from various services and sectors following experiences of DV. The research was conducted in collaboration with California domestic violence providers, multi-sector initiatives focused on DV/trauma prevention, and Futures Without Violence. The research focused on exploring three areas: 1) survivors' experiences navigating services provided by different sectors; 2) survivors' unique needs, aspirations, and challenges; and 3) survivors' suggestions for program/policy changes. Partners assisted with recruitment and logistics and reviewed interview guides, research protocols, and findings. Purposive sampling was employed to identify survivors who were 21 or older, had sought help from a minimum of two distinct service providers, and could provide a rich and illustrious description of their experiences. Selection bias was less of a concern given the exploratory nature of the research, limited data on survivor perspectives, and the importance of elevating survivors' voices to inform the design of multi-sector collaborations to prevent and mitigate DV. Thematic coding was conducted to explore key themes and ideas pertaining to research focus areas.

Interview respondents resided in the Greater Bay Area or Los Angeles County, were between the ages of 21 and 65, spoke English or Spanish, and represented diverse racial/ethnic and socio-economic groups. All but one interviewee identified as women. Interviewees had sought assistance from two or more services, DV programs, law enforcement, primary health, behavioral health, immigration services, and correctional offices, among others. Other findings from this research have been published as [stories](#) stories that can be downloaded and customized by DV providers and collaboratives to meet their needs; for example, to clarify the connection between DV and social determinants of health, to articulate their organizational value proposition, and to encourage partnerships and collaboration across diverse social service providers.

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