

HEALTH eBULLETIN

FALL
2017
INSIDE:



2 MESSAGE FROM THE EDITOR

**3 EXPLORING THE INTERSECTIONS
OF DOMESTIC VIOLENCE AND ACES:
ADVANCES IN DV ADVOCACY**

**8 INTIMATE PARTNER VIOLENCE
ADVOCACY AND HEALTH CARE
PARTNERSHIP INITIATIVES IN
OREGON**

**13 REIMAGINING SURVIVOR HEALING
AND SELF-SUFFICIENCY**

The Health e-Bulletin is a publication of the National Health Resource Center on Domestic Violence (HRC). The HRC is funded by the Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services

Editor: Linda Chamberlain PhD, MPH
Produced by: Kate Vander Tuig, Futures
Without Violence

FUTURES
WITHOUT VIOLENCE®

MESSAGE FROM THE EDITOR



Over 1,200 domestic violence advocates and health professionals recently convened at Futures Without Violence's National Conference on Health and Domestic Violence this past September, 2017

In this edition of the Health e-Bulletin, we are focusing on ground breaking strides in the field of domestic violence advocacy across the country to advance the health and wellness of survivors and their families.

We start by hearing about the work being done in Alaska to address Adverse Childhood Experiences (ACEs). Advocates were surveyed and reported back about their perceptions of ACEs and education for domestic violence advocates around how to address ACEs. The results of this survey are detailed in the article and highlight the importance of education advocates about addressing ACEs and what elements need to be included in education efforts.

The shift that advocates are making to prioritize survivor health and wellness is something that we are very excited to be seeing more and more across the United States. In the second article, we hear from advocates working in Oregon to forge and strengthen partnerships with health care providers through a project with the Health Resources and Services Administration and the Family Violence Prevention and Services Program at the US Department of Health and Human Services. Lessons learned from this project have been distilled into a new online toolkit for health providers and advocates!

Lastly we get updates from a DV program in Kentucky called GreenHouse17 that is operating with a unique and exciting model for advocacy that centers survivor self-efficacy and community collaboration.

Linda Chamberlain, PhD, MPH
EDITOR

EXPLORING THE INTERSECTION BETWEEN DOMESTIC VIOLENCE AND ACES: ADVANCES IN DV ADVOCACY

Linda Chamberlain, PhD, MPH
drlindachamberlain@gmail.com

Background | The Adverse Childhood Experiences (ACE) Study, which measured seven categories of potentially traumatic events including childhood exposure to domestic violence (DV), raised awareness of the high prevalence and cumulative effects of childhood adversities when it was first published.¹ Over the next three decades, scores of publications would demonstrate that ACEs are highly predictive of many physical, mental and behavioral health problems across the lifespan. Publication after publication was able to demonstrate a rare finding in public health research-- the more adversities that people experienced during their childhood, the greater the risk, in the absence of resilience and protective factors, that they would have health problems.

In the past few years, a national ACEs movement has emerged with more than 30 states having collected population-based data on the prevalence of ACEs among adults by adding an ACEs module to their state's Behavioral Risk Factor Surveillance System (BRFSS). The National Survey of Children's Health (NSCH) also added ACE questions (child abuse and neglect questions were excluded while other questions about neighborhood violence, socioeconomic hardship and discrimination were added) and provides data on the prevalence of ACEs among children for every state. While the survey questions asked and the types of adversities measured vary to some extent between surveys, a measure for childhood exposure to domestic violence has been included in both of these data sources.

Box 1: 7 Categories of Childhood Adversities Measured in the ACE Study

- » Physical abuse
- » Psychological abuse
- » Sexual abuse
- » Violence against mother
- » Household member abusing substances
- » Household member who is mentally ill or suicidal
- » Household member who was ever imprisoned

*Questions on physical and medical neglect were added in a later phase of the study

There are potential opportunities evolving with the ACEs movement for the field of domestic violence, such as additional data sources and increasing knowledge and resources on trauma-informed practices. There are also significant concerns about the implications of the ACEs movement for families experiencing domestic violence. Those concerns include an increased risk of reporting children exposed to domestic violence to child protection services, blaming or profiling DV survivors based on their childhood experiences and the rapid implementation of screening for ACEs without training or protocols to ensure safety and support for service providers who are doing the screening and the people being screened.

ACEs Training for Advocates | While there have been large scale ACEs training initiative in several states, these efforts may not have reached domestic violence service providers or address the intersection between DV and ACEs. A number of state domestic violence coalitions have addressed this gap by providing staff training on ACEs and implications for DV programs. This article describes

results from an online survey with the executive directors of domestic violence shelters and programs affiliated with the Alaska Network on Domestic Violence and Sexual Assault (ANDVSA), our state coalition. The survey was conducted in the spring, 2016, to inform the development of an educational toolkit for domestic violence advocates that was launched in a statewide training sponsored by the ANDVSA in February, 2017. While reviewing these results it is important to note that this is a small study population and that the ANDVSA has been pro-active on ACEs education, including content in their advocacy trainings over the past year.



Survey Results | The online survey was e-mailed to the executive directors from the 18 domestic violence shelters and programs that are active members of the ANDVSA. An advance letter was sent to the



executive directors to explain the purpose of the survey as described above. Three reminder emails with the survey link were sent after the initial launch of the survey. Seventeen of the 18 shelters/programs responded.

Nearly all (16/17) of the respondents indicated that they had seen information about ACEs in their community in the past year. Three-quarters (76.5%) of respondents thought that nearly all of the children being served by their programs had experienced other ACEs in addition to exposure to domestic violence.

In response to a question asking respondents what types of information they would like to see included in an educational toolkit on the intersection between DV and ACEs, the majority of respondents selected all of the seven options. One notable response was that all respondents wanted information about skills to help children self-regulate and heal.

There was greater variability in responses when asked how information about the intersection between DV and ACEs could be used by DV advocates and programs. Nearly all (16/17) responded that the information could be used to expand partnerships and coordinate services with other community agencies. The same number of respondents also indicated that they thought this information could be used to help parenting DV survivors to understand how ACEs can impact health, parenting and relationships. Three-quarters of respondents (76.4%) thought the information on DV and ACEs could be helpful in applying for grants to support children's services, parenting support, trauma-informed resources and interventions with clients. One-half (52.9%) thought this information could be used when working with batterers to help them understand the impact of childhood trauma/ACEs.

When asked about other sources of potentially traumatic events in their communities that have not been part of the ACEs research, all but one of the respondents noted historical/collective trauma. The second most frequently selected source of potentially traumatic events not included in the ACEs research was bullying (70.6%).

When asked, in an open-ended question, if there were special considerations, challenges and concerns that should be addressed when talking about ACEs in Alaska, issues related to historical/collective trauma and culture were the most common theme. One respondent advised, "never highlight the higher rates of trauma in the Alaska Native population without a discussion of historical trauma and how that might be playing a role in these rates of ACEs." Other considerations included the importance of having enough advocates or counselors at trainings to provide support and the need for specialized training in facilitating groups and forming healing steps so that no one is left without some form of closure after a discussion on ACEs.



A respondent, stressing the importance of having enough support for people receiving information about ACEs, stated “I’ve found that some folks have a difficult time and if there aren’t enough people in the room that leaves the traumatized individual not receiving immediate assistance.” Concerns about discussing ACEs in small communities where everyone knows one another or is related in some way and limited access to resources was also noted.

When asked about words and ways to talk about ACEs so that it is not overwhelming or retraumatizing, respondents suggested using language such as bad experiences, sad events in your life or tough times. It was noted that presenters need to be aware of their audiences and adjust accordingly. Normalizing that we have all experienced trauma, that it is part of life, was emphasized by one respondent who stated “ACEs doesn’t define us or who we are. We have the capacity to heal, to move forward.” The capacity to heal was a reoccurring theme.

Next Steps | The survey results are being combined with qualitative data from focus groups that were conducted with directors and staff at several domestic violence shelters in Finland to provide additional insights into the development of an educational toolkit on the intersection between DV and ACEs. Following the launch of the toolkit at a statewide gathering of advocates and community members which was sponsored by the ANDVSA in spring, 2017, this open access resource is available online at www.acesconnection.com. Qualitative findings from the research conducted in Finland, supported by funding from the Fulbright Arctic Initiative, will appear in a future issue of the eBulletin.

Box 2: Respondents’ Selection of Types of Information to Include in an Educational Toolkit on DV and ACEs

Type of Information	Number of Responses(%)
Information about ACEs among Alaskans.....	14/17 (82.4%)
How DV and ACEs are connected.....	15/17 (88.2%)
Impact of stress on children’s and adults’ brains..	13/17 (76.5%)
Skills to help children self-regulate and heal.....	17/17 (100%)
Stress reduction and healing practices for adults.	15/17 (88.2%)
Parenting strategies to help children through tough times.....	16/17 (94.1%)
Strategies and resources to promote community resilience and wellness.....	14/17 (82.4%)

References:

1. Felitti FJ, Anda RF, Nordenberg D, Williamson DV, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine. 1998;14(4):245-258.

RESOURCES FOR ADVOCATES

developed by advocates and survivors to promote survivor wellness and health access



A HEALTH CARE GUIDE FOR SURVIVORS OF DOMESTIC AND SEXUAL VIOLENCE

The physical and emotional harm that comes from being abused by a loved one can affect survivors even after the violence has stopped. The brochure offers trauma-informed recommendations for survivors about how to become proactive in their healthcare and how to best advocate for their needs with health care providers. Advocates can use this tool to safety plan with survivors who are accessing health services. Order this brochure in English and Spanish [here](#).

ACCESS TO HEALTH CARE FOR SURVIVORS

This is a time of tremendous change in how health care is delivered in this country and for many survivors, access to health care is a vital part of healing and self-determination. Futures Without Violence is working with advocates and health providers to get survivors across the country the access to the care and coverage they deserve. Learn more about health care enrollment and how you can promote access [here](#).

INTEGRATING HEALTH SERVICES INTO DV PROGRAMS

Prioritize survivor health and wellness at your agency by offering important health services such as reproductive health resources, pain medication, or rapid HIV testing. Reflect a culture of health for your clients and staff through wellness classes, healthy food options, and other health activities. Strategies on how to do this [here](#).



INTIMATE PARTNER VIOLENCE ADVOCACY AND HEALTH CARE PARTNERSHIP INITIATIVES IN OREGON

Christine Heyen, MA

*Oregon Safer Futures Project
Coordinator
Oregon Department of Justice, Crime
Victims' Services Division
christine.p.heyen@doj.state.or.us*

Emily Fanjoy

*Tillamook County Women's Resource
Center Safer Futures Project
Coordinator
emily@tcwrc.net*

Kimber Lundy

*Advocate
Tillamook County Women's Resource
Center and The Rinehart Clinic
kimber@tcwrc.net*

The rugged coastline of Tillamook County is host to forested shorelines, sandy beaches, secluded coves and rocky cliffs. This beautiful landscape is home to the [Tillamook County Women's Resource Center](#) (TCWRC) and [The Rinehart Clinic](#). TCWRC is a non-profit advocacy organization serving domestic and sexual violence survivors. The Rinehart Clinic is a federally qualified health center and primary care medical home serving patients in Wheeler, OR and north Tillamook County. TCWRC and The Rinehart Clinic are long standing partners and recently participated in [Futures Without Violence's Community Health Center Initiative](#). From November 2015 to September 2016, the two partners

have received training, technical assistance and resources to improve health outcomes for survivors of intimate partner violence (IPV), and in particular for those who are pregnant and newly parenting. As a result, both TCWRC and The Rinehart Clinic have improved their capacity for identifying and responding to IPV.

A 2009 community needs assessment, commissioned by TCWRC, found that one in three women and one in fifteen men in Tillamook County reported having experienced IPV, a rate higher than the national average. In August 2016, the Women's Foundation of Oregon published the "Count Her In" report that found women and girls in Oregon experienced rates of



Rebecca Levenson and Anna Marjavi from FUTURES visit with TCWRC staff in Oregon, May 2017 for a training on promoting survivor health.

domestic and sexual violence at rates higher than the national average.¹ National research points to the adverse impacts of IPV on women's reproductive and overall health: not limited to injuries, hypertension, anxiety, unintended and rapid repeat pregnancies and low birthweight babies.^{2,3} Childhood exposure to IPV was one of the potential sources of trauma measured in the Adverse Childhood Experiences study (ACEs), a collaboration between Kaiser Permanente and the Centers for Disease Control and Prevention.⁴ IPV contributes to even wider health disparities among communities of color and marginalized populations.⁵ As disheartening as this may seem, Oregon is at the forefront of cultivating new and innovative responses to IPV through models of collaboration between non-profit advocacy organizations and health care systems.

Oregon is at a unique crossroads because of the state's health care transformation efforts and the expansion of Medicaid through the Affordable Care Act. This has created opportunities for non-profit advocacy organizations such as TCWRC to collaborate with [**Oregon's Coordinated Care Organizations \(CCO\)**](#) and their network of health care providers.⁶ In this case, TCWRC and The Rinehart Clinic (a part of [**Columbia Pacific CCO**](#)) established a partnership with funding support from the Oregon Department of Justice's [**Safer Futures Project**](#), made possible by a Pregnancy Assistance Fund grant from the Office of Adolescent Health.⁷ The Safer Futures Project supports partnerships between advocacy organizations and health care systems across Oregon using four strategies. These strategies focus on increasing access to advocacy services for survivors, training health care providers on how to identify and respond to survivors of IPV, developing the capacity of non-profit advocacy organizations to deliver services in and to partner with health care systems, and improving health care system policies and practices for identifying and responding to IPV.

Prior to their participation in Futures Without Violence's Community Health Center Initiative, The Rinehart Clinic housed a community-based advocate from TCWRC to be on-site at the clinic. The advocate, Kimber Lundy, has offered services to survivors of IPV at The Rinehart Clinic since January 2013. Both TCWRC and The Rinehart Clinic welcomed the chance to participate in the Community Health Center Initiative, seeing it as an opportunity to strengthen the existing partnership. Members of the project leadership team, which included The Rinehart Clinic's CEO, Marge Jozsa, lead RN Denise Weiss, and Ms. Lundy, worked closely together with Futures Without Violence to coordinate training for TCWRC advocacy staff and The Rinehart Clinic clinical and administrative staff. Futures Without Violence provided [**comprehensive training curricula, health**](#)

care provider resources, and patient education materials. **Quality improvement tools** were used to guide the system changes necessary to institutionalize policies to assess for IPV, as well as resources to facilitate an ongoing and productive partnership between TCWRC and The Rinehart Clinic. In addition, qualitative and quantitative data was collected by TCWRC to point to the benefits of the partnership for survivors.

Partnerships like the one between TCWRC and The Rinehart Clinic have tremendous benefits for survivors of IPV, especially when a CUES intervention (Confidentiality, Universal Education, Empowerment and Support) is used.⁸ The **CUES intervention** uses the Futures Without Violence safety card for universal education and assessment. This tool, which addresses both healthy and unhealthy relationships, is patient-centered and trauma-informed. As was the experience of TCWRC and The Rinehart Clinic, the CUES intervention was most effective when the health care provider followed up the assessment with a warm referral to a community-based advocate. A community-based advocate like Ms. Lundy offers a robust menu of support, accompaniment and intervention services. Advocacy services include safety planning, information and referral, pregnancy support, emergency and transitional housing options, child care resources, connections to bilingual and culturally appropriate supports, skill building for healthy parenting and parenting after childhood trauma exposure, civil legal services, system navigation, assistance enrolling for health insurance and doula services.

Of the key take-a-ways that emerged from TCWRC and The Rinehart Clinic's participation in the Community Health Center Initiative, two stand out:

1) Non-profit advocacy organizations must have the capacity to meet the needs of the partnership (i.e. advocate availability and accessibility, meaningful and consistent communication with health care staff and management, active support of the CUES intervention through training

and consultation) and to offer a robust menu of advocacy services that ultimately improves survivors' health outcomes (i.e. to expand the definition of advocacy to include doula services, referrals to health insurance enrollment assistance, navigation of the health care systems, etc.); and

2) Health care partners must be willing to examine and adapt existing screening methods, referral protocols, provider practice and relevant clinic policies to better support survivors of IPV.

These and other lessons learned were captured in a step by step toolkit, **IPVHealthPartners.org**, that was made available by Futures Without Violence in partnership with the **Health Resources and Services Administration** and **Family Violence Prevention and Services Program** at the US Department of Health and Human Services in early 2017. This compendium of knowledge and experience will serve to help other partnerships to develop and thrive like the one between TCWRC and The Rinehart Clinic.

"She felt empowered. She was making choices that she had not been allowed to make for years. She was feeling stronger. She was listened to and believed. With support and skill building and plenty of her own strong will, she reduced the physical medical issues that had plagued her. We're still working together when she wants too. Triggers still come up, and when they do she uses her knowledge on grounding techniques to help her through." – Kimber Lundy, Advocate



References

1. Women's Foundation of Oregon, "Count Her In: A Report About Women and Girls in Oregon" <https://womensfoundationoforegon.org/uploads/CountHerInreport.pdf>
2. Smith SG, Chen J, Basile KC, Gilbert LK, Merrick MT, Patel N, Walling M, & Jain A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
3. Parker, B., McFarlane, J., & Soeken, K. (1994). Abuse During Pregnancy: Effects on Maternal Complications and Infant Birthweight in Adult and Teen Women. *Obstetrics & Gynecology*, 84(1), 323-328.
4. Felitti FJ, Anda RF, Nordenberg D, Williamson DV, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*. 1998;14(4):245-258.
5. Safer Futures webinar October 6, 2014 "Health Disparities for Communities of Color; Addressing Barriers to Care" http://www.doj.state.or.us/victims/pdf/health_disparities_for_communities_of_color_addressing_barriers_to_care_10-06-14.pdf; Communities of Color in Multnomah County: An Unsettling Profile <http://www.coalitioncommunitiescolor.org/cc-c-dataresearch/>
6. A coordinated care organization is a network of all types of health care providers (physical health care, addictions and mental health care and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan.
7. Oregon's Safer Futures Project is made possible by the Pregnancy Assistance Fund Grant #1SP1AH000016 from the Office of Adolescent Health, U.S. Department of Health and Human Services. Contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Human Services or the Office of Adolescent Health.
8. Research shows that women who talked with their health care provider about abuse were four times more likely to use an intervention and 2.6 times more likely to exit an abusive relationship. McCloskey LA, Lichter E, Williams C, Gerber M, Wittenberg E, Ganz M. Assessing Intimate Partner Violence in Health Care Settings Leads to Women's Receipt of Interventions and Improved Health. *Public Health Reporter*. 2006;121(4):435-444.



New Web-based Resources from the National Health Resource Center on Domestic Violence

relationships can affect health

learn how you can support intimate partner violence
survivor wellness and promote healthy relationships

ipvhealth.org

Everything you need to address domestic violence and sexual assault in *all health settings* and promote survivor health and wellness at domestic violence advocacy agencies.

ipvhealthpartners.org

A step-by-step toolkit developed for and by *community health centers, in partnerships with DV programs*, aimed at establishing and expanding partnerships between health centers and domestic violence advocacy agencies.

get access to:

- advocate specific tools
- sample model policies
- training and quality improvement tools
- reimbursement strategies
- multi-lingual and cross-cultural patient and provider tools
- and much more!

New digital tools from The National Health Resource Center on Domestic Violence, a project of Futures Without Violence. Funded by the Family Violence Prevention & Services Program, Family & Youth Services Bureau, Administration for Children and Families, and the Health Resources and Services Administration at the U.S. Department of Health and Human Services.

REIMAGINING SURVIVOR HEALING AND SELF-SUFFICIENCY: A DIFFERENT KIND OF ADVOCACY IN KENTUCKY

Darlene Thomas, MSSW
dthomas@GreenHouse17.org

Executive Director
GreenHouse17

"The dew on the grass, the birds chirping, and the different colors...I gardened with my great grandfather until my teens, when hormones took precedence over soil, nature and hard work. A fellow gardener asked me to help "rescue some flowers." It was then that I saw them as living things. I appreciated that. I went on a spiritual journey the first day gardening, and I look forward to going back..." –K, field note from survivor participating in the stipend program

On an evening twelve years ago, I stood at the back door of an empty building on 40 acres of rural farmland in central Kentucky. The grass and trees seemed to glow in the golden light of the setting sun. Feelings of safety and possibility warmed my soul as the sun lowered in the sky. I imagined a small group of survivors sitting on the back porch and sharing their stories as day peacefully transitioned to night.

This sunset was giving me answers to questions I had been asking for weeks. Our organization had outgrown our small urban-based shelter for survivors of intimate partner violence. Although a move was imminent, I was struggling with the decision to relocate

our organization so far from downtown Lexington, Kentucky. How will survivors stay connected with community service organizations in the city? Can we engage supporters of the mission from this rural location? How could our program go beyond crisis services to make sure that we were promoting health and healing of survivors and their families?

Before the sun dipped below the horizon that night, the decision was made. This building would become our new home.

Getting Started | While settling into our new facility, we began to consider how to integrate the land with the delivery of direct services for survivors. Maybe equine therapy or a



herd of sheep? Although neither of these options proved to be the right fit, early dialogues confirmed the land must enhance existing traditional services for survivors, while also providing a source of revenue to help sustain our agency. Local and national conversations were beginning to explore topics related to food deserts, local food production, and social entrepreneurship. We convened community experts to discuss how our land could be used to address these issues.

The commitment of staff and resources to achieve this integration would be substantial. We started small with only a few box gardens of seasonal herbs and vegetables for use in meal preparation for shelter residents. We honed our gardening skills and observed interest in the effort over the next two seasons. Consultations with arborists and farmers informed our land use plan, and local garden clubs provided native cuttings and seeds for planting. A generous grant from **Grow Appalachia**, a partnership with Berea College and John Paul DeJoria's

Peace Love and Happiness Foundation, allowed us to hire a Farm advocate to manage the farm and programming. This early financial commitment allowed us to leverage additional support from United Way, Kentucky Utilities, and Toyota Motor Manufacturing, Kentucky.

Without best practices specific to farm-based programs for survivors of intimate partner violence, we sought related research to guide our endeavor. Publications about therapeutic gardening and trauma-informed care for women veterans informed our vision for the farm to be a space for nature-based healing. Several studies demonstrated positive effects of gardening on stress levels and general health, an especially important factor when the health implications of intimate partner violence are considered. Research analyzing the individual and community benefits of social farming in Europe validated our belief that the farm would encourage connectivity, bringing together survivors and mission supporters in mutually beneficial interactions.

Staying Open to Change | While developing our early farm plans, we thought vegetables production would be our primary focus. Our community had other plans. A few years ago, survivors and staff had planted a small garden of flowers. Representatives of Kentucky Proud, a state marketing program for agriculture, admired the flowers during a visit to the farm. They asked if we might put together some small table bouquets for their kick-off breakfast at the State Fair. Soon after the event, calls and e-mails requesting bouquets of our flowers for centerpieces overwhelmed us. While growing vegetables for healthy meals in shelter continued the next season, the expansion of our flower production became a priority.

Around this same time, individuals and private foundations stepped in to fund the renovation of an outbuilding on the back of our farm program, called GreenHouse17, for much-needed space to fulfill flower orders and facilitate workshops for survivors. Special attention was given to the



Flowers grown and arranged by survivors participating in the GreenHouse17 stipend program



“I had fun this week working on the farm. It was calming and exciting. I love learning new things. My dislikes this week snipping my finger while harvesting, even though harvesting is my favorite thing so far. I love finding vegetables from last fall and feeding them to the horses. They enjoyed the carrots too. I am excited about next week can’t wait to see what it will bring.” –C, field note from survivor participating in the stipend program

renovation to meet certified commercial kitchen requirements. Today, this building is the hub for production of value-added products from the farm, including lip balms, artisan soaps, aroma sprays, and other **Handmade By Survivors** products that feature ingredients grown on the farm.

Growing flowers and manufacturing Handmade By Survivors products mirror our organization’s commitment to empower survivors with resources and encourage self-sufficiency. Adults living at our emergency shelter have the option to participate in workplace training on the farm in exchange for a small stipend, and our farm manager serves as a current work reference when participants receiving stipends apply for jobs. We recently introduced new paid apprenticeships on the farm for

survivors who demonstrate continued interest in agricultural production.

Measuring Effectiveness | While our farm programs are encouraging survivor healing and self-sufficiency, our organization is also striving to make the farm a successful social enterprise. To borrow an informal phrase, the farm encourages us to “walk our talk.” In much the same way the farm provides survivors with the opportunity to grow through nature-based experiences, it provides an opportunity for community supporters to engage in tangible and meaningful activities that contribute to the mission of ending intimate partner violence. Annual sales of our flowers and handmade products have reached \$40,000, and each year sales have increased about 13%.

Data tracked by our organization indicate the farm-based programs we have developed are effectively growing and having positive impact on our clients and community. Those few early box gardens have grown to almost 7,000 square feet of cultivated land. We harvested 4,482 pounds of vegetables and herbs this past year! This means every adult and child living at our emergency shelter has access to nutritious field-to-table meals, which is an important part of health, healing and community for many families. Approximately 60% of shelter residents directly participate in at least one nature-based program during their stay with us. We believe that all survivors living at our shelter benefit from indirect engagement with the farm. More than 30 adult survivors participated in our farm stipend program this year, and sixteen found a new job before leaving shelter.

A recent grant awarded to the University of Kentucky Research Foundation will fund the examination and evaluation of GreenHouse17, our farming program, over the next three years that will culminate with a publication of outcomes. I anticipate that this research will give credence to anecdotal evidence survivors have provided through conversations and letters, like these words written by Donna, who gave us permission to share her experience:

“I was confused when I first came in the door. I cried a lot and wasn’t sure who to trust or where my life was going...I would come out to work on the farm every day. It was a sense of accomplishment. You wake up and have something to look forward to. I came out here and was able to let my mind go. I didn’t have to worry about the stresses that were on me. I was working with my hands to build something, not only for me but to feed the house and help the other girls... If I could help them more than myself, that was a good thing, and that was what kept me going. After what I went through, I realized I wasn’t so self-sufficient. The

farm has helped me realize I can do it. I can start something and finish it. And do it on my own. I can watch something grow from the beginning stage to the end stage and see the result that it has.”

GreenHouse17 is not only supporting survivors’ independence and self efficacy, but provides space for them to focus on their own health – something they may not have been able to do while surviving abuse.

NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE SAFETY CARDS: AN EVIDENCE-BASED INTERVENTION TO PROMOTE HEALTHY RELATIONSHIPS AND EMPOWER SURVIVORS OF DOMESTIC AND SEXUAL VIOLENCE

Check out our multilingual, low-literacy patient education safety cards that provide information on healthy and unhealthy relationships, their impact on health and list national referrals for support. The evidence-based safety card tool was developed to help clinicians and domestic violence/sexual assault (DV/SA) advocates have open conversations about DV/SA and healthy relationships with their clients. In partnership with health care providers, advocates and survivors, we have developed the following:

Setting Specific and Topical

- Adolescent Health
- ACEs
- Behavioral Health
- HIV Testing and Treatment
- Home Visitation
- Pediatrics
- Perinatal Health
- Primary Care/General Health
- Reproductive Health

Population Specific

- American Indian/Alaska Native
- College Campus
- Hawaiian Communities
- HIV+
- LGBTQ
- Parents
- Pregnant or parenting teens
- and coming soon...Muslim youth



All cards available in English and most in Spanish. Our Primary Care/General Health safety card is available in the following languages: Chinese, Tagalog, Hawaiian and coming soon: Vietnamese, Korean, Armenian and French

To view and order visit
IPVHealth.org/resources/

THE HEALTH E-BULLETIN IS PRODUCED BY THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE.

For free technical assistance and educational materials:

FuturesWithoutViolence.org/health
IPVhealth.org

M-F 9am-5pm 415-678-5500 TTY: (866) 678-8901
health@FuturesWithoutViolence.org



ABOUT THE NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE:

For more than two decades, the National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence. A project of Futures Without Violence, and funded by the Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services, the Center supports leaders in the field through groundbreaking model professional, education and response programs, cutting edge advocacy and sophisticated technical assistance. The Health Resource Center offers a wealth of free, culturally responsive materials that are appropriate for a wide variety of health professions and settings.