The Safer Futures Model: Developing Partnerships between Intimate Partner Violence and Health Care Agencies
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This column highlights lessons learned from the Safer Futures model, which resulted from an effort to build successful partnerships between health care providers and intimate partner violence (IPV) agencies using a colocated advocate model. Using a “no wrong door” approach, the goal of Safer Futures is to increase access to IPV services for pregnant and newly parenting women. A demonstration project of the Safer Futures model was funded through the Pregnancy Assistance Fund in five different locations in Oregon. Here we present a brief description of the Safer Futures model and focus on the lessons learned during implementation to inform practice.

BACKGROUND
IPV is a well-documented social determinant of health with clearly demonstrated health impacts and associated costs. Bonomi, Anderson, Rivara, and Thompson (2009) found that the health care costs of women who experience abuse are 42 percent higher than those of nonabused women. Health problems associated with domestic violence include chronic pain, irritable bowel syndrome, pelvic inflammatory disease, sexually transmitted diseases, substance abuse, posttraumatic stress disorder, depression, and suicide attempts (Evanson, 2006). Although violence occurs across the life span, during pregnancy women are at risk for depression, delayed prenatal care, and premature labor, and their babies are at risk for fetal trauma and low birthweight (Taillieu & Brownridge, 2010). Finally, physical and psychological abuse during pregnancy is associated with increased risk of postpartum depression and substance abuse (Taillieu & Brownridge, 2010).

The health care system has not yet developed an effective response to this issue. For example, the rate of screening for IPV by health care providers remains low despite recommendations by the Health and Medicine Division (previously the Institute of Medicine), the U.S. Preventive Services Task Force, and inclusion in the Patient Protection and Affordable Care Act (Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). This failure is attributable at least in part to clinicians’ concerns about fear and loss of relationships with patients, time constraints, lack of knowledge about domestic violence, and inadequate resources and support staff (Chang et al., 2009; Sprague et al., 2013). Moreover, there is evidence that screening on its own is not enough because clinicians often do not know what to do when a patient discloses IPV (Morse, Lafleur, Fogarty, Mittal, & Cerulli, 2012). Coker et al. (2012) found that on-site advocacy interventions had positive implications for reducing violence and improving a woman’s well-being over time. IPV advocates who are trained in best practices around safety planning, survivor needs, and confidentiality have the expertise, experience, and dedicated time to focus on survivor needs, whereas clinicians often do not.

SAFER FUTURES MODEL
The Safer Futures project is a partnership between IPV agencies and health care providers in five rural, low-resource communities in Oregon. The health care setting and advocate varied in each individualized partnership. The goal of the project was to increase screening and access to IPV services in health care settings.

The Safer Futures model colocates IPV advocates in a variety of medical settings to provide services for pregnant and newly parenting women. As part of the model, health care professionals including doctors and nurses are trained by partnering...
IPV agencies in universal screening of patients for concerns around IPV and healthy relationships. Pregnant and newly parenting patients who disclose IPV are immediately connected to a Safer Futures advocate located in the clinic for additional services.

As paraprofessionals who receive 40 hours of IPV-specific trainings, IPV advocates are less expensive and uniquely qualified to provide IPV-specific services. This can be especially important in rural areas where clinics often cannot afford an on-site social worker or behavioral health specialist. Women in rural areas face multiple barriers to accessing health care including transportation, access to specialty providers, stigma, and privacy concerns (Gamm, Hutchison, Dabney, & Doney, 2003) that are amplified when IPV is present. The Safer Futures model is designed to address these challenges and improve women’s access to health care and other services to improve well-being.

The Safer Futures model changes the way the health care system typically interacts with survivors of IPV in a variety of ways. Advocates are on-site to provide immediate in-person IPV-related services. In addition to the typical IPV advocacy services, advocates may assist with health care navigation, accompaniment services to medical appointments, and reproductive health support. Colocated advocates can also help facilitate the integration of care by connecting IPV-related health issues (for example, stress, anxiety, substance use) in primary and behavioral health care settings, thereby improving overall care quality. Finally, advocates are readily available to provide case-specific consultation, technical assistance, and IPV-related training to health care practitioners. In turn, advocates improve their knowledge of the health care system and issues related to women’s health, which can inform their work with other survivors and be shared within other IPV service communities.

**PRACTICE AND PROGRAM LESSONS LEARNED**

The Safer Futures project generated a variety of lessons learned related to services and partnerships between IPV agencies and health care providers. Implementation is not without challenges, including competing demands of clinician time and fee structures that are continually being navigated. Fee structures continue to be an ongoing issue given limited funding and reimbursement opportunities. Colocated advocates in this model are funded and employed by the IPV agency. Partners continue to evaluate and discuss ways to expand funding opportunities to support colocated IPV advocates in health care settings.

**Developing Partnerships**

A key lesson learned is that developing durable partnerships takes time, energy, and commitment. The Safer Futures model included an IPV agency-based partnership development coordinator devoted to identifying and building relationships with potential health care partners. Search for partners was focused and multilayered, looking for providers serving populations disproportionately experiencing IPV such as pre- and postnatal care, family practice, family planning clinics, high school-based clinics, and mother-focused substance use programs.

When developing partnerships, it is important to demonstrate familiarity with key features of the local health care landscape such as provider networks, funding streams, and common practice models while articulating the added value of advocacy services. Providing opportunities for meaningful interactions and mechanisms for ongoing communication may reduce resistance to new partnerships and increase cohesion.

**Legal and Ethical Concerns**

In creating Safer Futures partnerships, one of the most common concerns was confidentiality and information sharing. These included space for private conversations with survivors, access to medical records and other protected information, documentation practices that may increase survivor risk, and mandatory reporting requirements. Safer Futures negotiated with individual partners to establish clear guidelines around information sharing and confidentiality at the beginning of the partnership. Agreements needed to reflect not only state and federal regulations such as mandated reporting and patient privacy protections, but also any unique agency-level practices (for example referral process, documentation). These agreements were clearly communicated to health care staff, especially those working closely with advocates to ensure consistency across the team. Individual partnerships developed different solutions to provide private conversation space for advocates while not restricting exam room space. In addition, it was important to discuss with partners the options and process of anonymous consultations with advocates during which clinicians do not disclose a
survivor’s identity and signage that stated that all patients were to meet with clinicians and other clinic staff in private that made it possible to talk with survivors alone without raising suspicions.

**Clinician Time**

Resistance around screening was often related to clinicians feeling pressed for time with patients. Screening for IPV is just one of the many health-related issues they need to cover during clinic visits. To increase screening and ensure consistent messaging, clinicians were provided with scripts they could consult when talking about IPV and the advocate services. In addition, clinicians completed warm handoffs of survivors to IPV advocates. The clinicians found value in being able to connect survivors immediately with a variety of services without infringing on their time. The Safer Futures advocates were able to help with an array of services including accompaniment to medical appointments, education and support around trauma, and IPV and health effects education. Clinicians also reported that they viewed IPV advocates as part of the medical team and their presence reminded them to talk about IPV with patients.

**CONCLUSION**

The Safer Futures model works on multiple levels to improve well-being. In addition to providing on-site services to women experiencing IPV, it also changes and shapes the practice of medical practitioners to increase IPV awareness and screening. A multifaceted evaluation of the Safer Futures program to gather empirical data about the short- and long-term benefits of colocated advocates to help counter some of these challenges has recently been completed and is currently being developed for publication. HSW

**REFERENCES**


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