Partnering Providers and Advocates for Child Wellness and Family Stability

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The experience of domestic violence is closely linked to the health and financial well-being of both women and children. Over half of the women receiving public benefits have experienced physical abuse by an intimate partner at some point in their adult lives, compared to 22% of the general population.[1]

The Medical-Legal Partnership for Children (MLPC), currently serving six community health centers in the Boston area and located within the pediatrics department of the Boston Medical Center (BMC), practices preventive law for families with unmet legal needs. MLPC is a collaboration of front-line health care providers, mental health clinicians, and legal advocates working to improve children's health and well-being. MLPC's central goal of providing legal assistance in a preventive manner before the family reaches crisis is modeled on the prevention culture that exists in pediatrics. By offering legal assistance at an early stage, lawyers can help clinicians and families answer important questions about immigration status, employment, and benefits that can help women leave their abusers and keep their children safe.

The Child Witness to Violence Project (CWVP) provides trauma-informed counseling and advocacy services to young children and parents who have been affected by domestic or community violence. The CWVP is located at BMC and staffed by a multi-cultural, multi-lingual staff of social workers, psychologists, early childhood specialists, and a consulting developmental pediatrician.

In the case described below, MLPC and CWVP staff worked together to respond to the complex advocacy needs of this family in a manner that impacted directly the wellness and stability of the family. The issues presented in this case intentionally do not revolve around the classic paradigm of domestic violence where systems are able to respond with such interventions as emergency shelter and restraining orders. Instead, the case below portrays the health consequences of domestic violence and the necessity for a multidisciplinary response.

1. Richard Tolman and Jody Raphael, A Review of the Research on Welfare and Domestic Violence, 56 J. of Soc. Iss. 655 (2000); Sharmila Lawrence, Research Forum on Children, Families, and the New Federalism, National Center for Children in Poverty, Domestic Violence and Welfare Policy: Research Findings That Can Inform Policies on Marriage and Child Well-Being, Issue Brief (2002); Eleanor Lyon, Building Comprehensive Solutions to Domestic Violence, Publ'n No. 10, Welfare, Poverty and Abused Women: New Research and Its Implications, (2000).

The Mendoza Family*

The Mendoza family* was referred to MLPC by the CWVP. The maternal grandmother of the family had custody of her two granddaughters, whose mother was shot and killed by their father in front of the granddaughters. The two children and their grandmother were being seen for counseling services in the aftermath of the murder. Despite the murder, the father sought and obtained court-ordered visits with the children. The grandmother relied on social security payments to support her granddaughters, and as a result was under constant financial strain. They lived in public housing with the grandmother's other daughter and son-in-law and frequently lacked adequate food. In the winter, the family was unable to pay the high heat costs and the utility companies threatened shut off due to nonpayment. The Department of Social Services (DSS) had an open case regarding neglect of the granddaughters due to the drug involvement of the son-in-law. DSS suggested that the grandmother and her granddaughters move out of the home.

MLPC first consulted with the referring clinician to discuss the most acute advocacy issues, including the pending utility shutoff and safety concerns. The MLPC housing lawyer explained the utility winter shut off moratorium for low-income households to the referring clinician and provided the necessary forms and fax numbers of the gas and electric companies to insure immediate shutoff protection.

After conducting a thorough intake with the grandmother, including obtaining releases to speak with different agencies on her behalf, MLPC triaged the housing, child protection, and income supports issues and assigned different staff specialists to each issue. The housing, family law, and income supports attorneys and CWVP clinicians worked together to develop an advocacy strategy for the family.

Once MLPC verified that the family's utilities were protected, the housing lawyer contacted the grandmother and advised her regarding timelines for public housing transfers or conducting a private housing search. The attorneys cautioned the grandmother about the potential consequences of continuing to live with her son-in-law, outlining that she would risk further involvement with DSS if she remained in her son-in-law's home. The lawyer suggested that the grandmother look for housing in the private rental market, an option she could exercise with additional income supports. The housing lawyer then enlisted the CWVP clinician to help communicate this step to the grandmother, which included providing her with housing search workshop information in a counseling session. The family law lawyer referred her to a local legal services agency for assistance with the father's visitation order, so that she could seek the appointment of a guardian ad litem for the children's best interests.

Finally, the income supports lawyer screened the family's eligibility for income supports, contacted the grandmother and advised her to apply immediately for food stamps and welfare for herself and the grandchildren. The grandmother was able to apply for and receive benefits, as a relative guardian, and the additional income supported her choice to pursue private rental housing.

MLPC advocates and CWVP clinicians provided coordinated advocacy and support to the grandmother and assisted her family in avoiding the crisis of DSS removing the granddaughters from the grandmother's custody. The combined advocacy efforts enabled her to gain economic stability. MLPC and CWVP engaged advocacy strategies going beyond restrain-

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ing orders to affect positive outcomes. The granddaughters' reported stress level and school attendance improved immediately after the grandmother was able to move into her own housing.

Meeting the Challenges in Coordinated Advocacy: Training, Consultation and Confidentiality

While a partnership between clinical partners and lawyers can assist families affected by domestic violence and ensure a family's overall well being, there are challenges to creating an effective partnership model. These challenges include adequately training providers to screen families for legal issues, managing clinical provider expectations, acknowledging and adhering to confidentiality constraints, and assessing the client's readiness for advocacy services.

Provider education and training are an integral part of the partnership between clinical providers and advocates. MLPC has developed a curriculum for residents, faculty, and other healthcare providers called the "Advocacy Boot Camp Series: Training Our Clinical Partners in Advocacy." The goal of Boot Camp is to empower clinicians to screen for unmet advocacy needs and infuse their practice with advocacy awareness to assist them in making referrals to MLPC for advocacy services.

Managing provider expectations is a key challenge in medical-legal partnerships. MLPC has designed a case consultation practice that is modeled after "curbside consults." This case consultation practice is a critical component in setting provider expectations and engages providers in ongoing education about advocacy resources and strategies.

Efficient triaging of provider advocacy screenings is another key element of the work. MLPC advocates wear beepers to enhance accessibility to providers who may seek to consult with an advocate to assess whether a referral should be made to the program or whether the provider can triage the issues and provide the family with advocacy information or support. The outreach and consultation components of MLPC can play a unique role in preventing advocacy crises.

There are also distinctive confidentiality concerns in partnering clinicians with advocates that deserve thorough and ongoing examination. MLPC staff has published a variety of articles detailing the ethical challenges of medical-legal partnership and strategies for meeting the challenges. On a basic level, clients in the advocacy relationship through MLPC must be given clear and thorough information about the nature of the confidentiality concepts and guidance about proper releases under HIPPA and other applicable rules.

Domestic violence destabilizes the family and impacts caretaker-victims' ability to meet the basic needs of children. The children of women seeking safety have a range of needs that requires a multidisciplinary response. MLPC's approach partners advocates and clinicians to provide advocacy bridges for safety and stability for women and children affected by domestic violence and other social and economic conditions. Addressing the basic needs for safety and stability is the first step toward helping children heal from the trauma of exposure to domestic violence. Once basic needs have been addressed, the child and family are able to more fully engage in counseling.

Providers can disrupt the link between poverty, domestic violence and poor child health by making early consultations with legal partners to provide the opportunity for preventive advocacy. Providers can also help communicate the advocacy options and implications to the family and gain insight into the family's strengths. Lastly, providers can continue to triage unmet legal needs and assess their patient's advocacy readiness for effective collaboration with their legal partners. ■

For more information and contact numbers, please go to MLPC's website, www.mlpforchildren.org.

** This case study is a hypothetical based on families served by MLPC and CWVP.*

Save the Date: January 15, 2008

Domestic Violence Forum

NHP will be sponsoring a Domestic Violence (DV) training and speaker forum for providers. The goal is to offer providers at early stages in their program development an opportunity to learn more about domestic violence prevention and interventions. In addition, the forum will offer providers who already have established programs an opportunity to further enhance their learning and programming and to discuss successes and challenges in their DV prevention and intervention efforts. NHP will be applying to obtain CEUs for Nurses, Social Workers, Psychologists, Mental Health Clinicians and CMEs for Physicians.

Where: The Conference Center on the campus of the Massachusetts Medical Society in Waltham, Massachusetts

What: 'Domestic Violence 101' Training
Best Practices Speaker Forum

Speakers include:

Annie Lewis-O'Connor, Ph.D., M.P.H., APRN, a Nurse Practitioner and Sexual Assault Nurse Examiner who works on the Child Protection Team at Boston Medical Center. Dr. O'Connor is also an Assistant Professor at Boston University Medical School and has extensive experience with issues of domestic violence.

Peter Stringham, M.D., a Family Practice physician who was at East Boston Community Health Center for 30 years and worked extensively on violence prevention within the community.

Laurie Costigan, Psy.D., LMHC, the Domestic Violence Coordinator at Great Brook Valley Community Health Center in Worcester.

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