

MCHB/DPSWH Webcast

Increasing Your Program's Capacity to Address Perinatal Domestic Violence

May 12, 2004

KAREN HENCH: Good afternoon, everyone. Welcome to the Maternal and Child Health Bureau webcast on increasing your program's capacity to address perinatal domestic violence. I'm Karen Hench and I would like to welcome you to this webcast. Before we get started, I want to read from technical information that you may need as we go through the broadcast. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentation. You don't need to do anything with the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control on the top of the messaging window. We really encourage you to ask the speakers questions at any time during the presentation. All you need to do is type your question in the white message box window on the right of your screen and select question for speaker from the dropdown menu and then hit send. Please include your state or organization in your message so we know where you're participating from. These questions will be relayed to the speakers throughout the broadcast and we'll address your questions at the end of the broadcast.

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the end of the broadcast and there will be an evaluation. Please out the evaluation. We want to hear from you and give us information to provide future broadcasts in the series and to improve our technical support.

I want to introduce our speakers today. Rebecca Whiteman is a senior health analyst with the family violence prevention fund based in San Francisco, California and she is in our Chicago studio. Joining me here in Rockville, Maryland, is Pat Parker who is a senior outreach specialist and Kim Greenwood who is a nurse. They are in the HEALTHY START program that are involved in strategies to improve their program's ability to address domestic violence. This webcast is to familiarize you with the Maternal and Child Health Bureau to address domestic violence and help your program to improve screening and intervention for domestic violence during the perinatal period. The Maternal and Child Health Bureau which is situated within the health resources and Health Resources and Services Administration is one of the many agencies of the federal Department of Health and Human Services. MCHB administers the Title V grant as well as the HEALTHY START program and has as its general purpose involving programs to address the health of all mothers and children in the nation. So this has significant implication on the responsibility associated with services for pregnant women and also for screening and intervening for domestic violence.

MCHB for years has funded two key programs. First in the year 2000 we funded four domestic violence projects with the purpose of increasing perinatal provider screening, to provide appropriate intervention services and to really develop and enhance the sites

where women were screened for domestic violence which were prenatal care sites and women's shelter, law enforcement programs, consumer advocacy and other social support resources. Building on what we learned from those original grants in 2002 we were able to fund four more programs. I wanted to mention that the four original programs that were funded were at the Johns Hopkins Center for pregnancy in Baltimore, one in the Washington State Department of Health based in Seattle. One for the Illinois Department of Human Services in Saint Claire County and another through a medical center focusing on a community health center in the Bronx. And then in 2002 we were able to build on these experiences and to fund four more projects to address family violence. These grants were not only packed with the same objective to improve screening and intervention but also to address the violence that may be occurring within the families of clients so they would also link with child abuse, elder abuse programs and these grants went to four sites. One in the Portland, Oregon, another in Philadelphia, a third in a different county in Illinois, and then the fourth in North Carolina through the Raleigh area. We've also just this year have been able to provide family violence technical assistance to over 20 HEALTHY START grantees to help take the grantee from where they were with their ability to build capacity around screening to really improving the intervention services that were provided by those HEALTHY START sites.

I would now like to turn to Rebecca Whiteman who will give you more information on assistance provide and some of the basic information she's been able to share with HEALTHY START grantees around screening and intervention.

REBECCA WHITEMAN: I wasn't live for a second there. So you got to see my mouth moved. We fixed that, I think. I said thank you, Karen. And let's see, I said I have had the opportunity to come to any number of programs at this point and learn from the wisdom of HEALTHY START programs as well as the family violence grantees and so what I'm going to be doing is talking a lot about specifically how violence affects the perinatal period and a little bit around children exposed to violence in these next few slides and hopefully at the end I'll have a moment to talk about best practices I've seen from my site visits. Needless to say I've been lost in many states in the -- at this point over the last few months. I brought up a slide actually on the working definition of domestic violence because I think that traditionally folks have a very specific image in their minds when they think about domestic violence. They have the black eye image. And I think the sexual assault piece and the emotional piece is really important to look at along with the other areas, but I think it is especially important for HEALTHY START programs and any of their counterparts because much of what I've seen thus far in my site visits is that if folks are asking questions about violence it's typically limited to the physical violence and doesn't include these other areas. And we know that both sexual violence and emotional violence can have as great an impact on various aspects of health, including sexually transmitted infections, depression and the like. It's important for us to take that piece of information into account when we're looking at the issue of violence.

Briefly, too, I thought we should talk a moment about the magnitude of the problem and we know depending upon the study, that this is something that violence in a relationship is something that affects one in three or one in four women over the course of their lifetime.

We know that domestic violence affects men by for the purpose of our training today we're focusing on women. One story I want to mention to you around screening for violence and that actually came out of my North Carolina site visit. One of the case managers there said, you know, I had an interesting thing happen. I was talking about the importance of using gender neutral language when screening for violence. She said I had this young pregnant woman in my session and she brought her friend in that she was sitting next to and I wouldn't have ever known it had her friend not disclosed but in fact her friend was her partner, this woman was a lesbian. She had gotten pregnant because she wanted to be a mom. It had never occurred to me. She said for her it caused her to pause and really think about, you know, using words like boyfriend and husband when working in a perinatal setting. I thought that story was worth sharing here.

We know that every -- basically every major medical association has come out with a position paper or policy statement around the importance of screening for domestic violence. The American nursing association, the AMA, American public health association and, too, we also know that in 2002 the World Health Organization declared violence a worldwide public health issue. There were -- one of the sites that I had the opportunity to go to actually had a clinic-based program in a high school and I know that there are any number of programs that work in conjunction with adolescent-specific programs if they don't have a component that is very focused on adolescents within their program. I think it's so important to think about our opportunities as leaders around caring about women and kids to see how we can influence elementary school and middle school and high school curriculums. By the time they're in middle school we know that 25% of those 8th

and 9th graders have disclosed dating violence and one in five high school students have disclosed sexual violence from a dating partner. We need to start talking about healthy relationships before someone finds themselves in that kind of relationship.

What Karen didn't mention to you is a little bit about my background. I was a clinic director for planned parenthood for a long time and we ran a large-scale pre-natal program along with having traditional pregnancy testing as well. This was information that was new to me several years ago. It was that adolescent girls who experience physical and sexual dating violence are six times for likely to become pregnant than their non-abused peers. All of a sudden I had to stop and think about pregnancy testing in general and a number of programs that we've been working with I was just in -- I was just in which county in Illinois? I've been into cook county. And that particular HEALTHY START program also has a clinic-based program and we were talking about pregnancy testing and often that is sort of a one-shot visit. And it's not necessarily connected to a physical exam. And in thinking about adolescent girls and the likelihood of pregnancy and violence, I realized within my own program that we had an incredibly missed opportunity to integrate screening for violence as part of that pregnancy test to educate those young women about what could be happening to them.

This next slide actually goes along with that thinking about the likelihood of pregnancy with adolescents and that is -- I think this is one of the more surprising slides in the presentations that I've done. That 51% of young moms on public assistance had experienced birth control sabotage by a partner. When we started out looking at the

definition of domestic violence I looked at physical violence and emotional abuse but I think folks don't necessarily think about this kind of sabotage being another thing to screen for in terms of controlling partner in a relationship. So, when we think with screening adolescent girls and talking about for pregnancy, talking about the opportunity to ask them whether or not they're able to talk to their partners about the birth control they use and if their partner is supportive of that would be a really important thing to include in those conversations.

Most of the programs that I have visited ask questions about whether or not the pregnancy was intentional and I think this slide is helpful in terms of I think there is many different tipoff's to maybe something is not OK in the relationship that are sometimes missed and certainly I think a significant to note that unwanted or mistimed pregnancies are four times more likely, women who have been abused are four times more likely to experience an untimed pregnancy when their counterparts. When we were checking out that form my staff weren't aware of that. It wasn't an indicator for them but I think it's an opportunity for us to do that educationally with our staff. I did want to mention that the slides that you're seeing today are all available and downloadable off the web. So the whole goal actually of this technical assistance practice project and what the family violence prevention fund does is to develop leadership internally and build that capacity inside.

You'll be able to take these slides and at the end of the presentation I'll be giving you information on how to contact us and our website that's downloadable, free and we encourage you to use this to educate your staff. In terms of prevalence during pregnancy.

Depending upon the study the rates range from 7.4% to 20%. And when I was a director for Planned Parenthood I had a grant to look at this issue to integrate this screening in my clinic and I thought we were doing a good job because we had that question about physical violence on our form. We had for ten years. I thought hey, we're doing a good job and you know how you learn more and you just become more and more humble as time goes on? I went to my first big training by the family violence prevention fund and there was a wise woman in the audience who asked the question about how often we were getting disclosures. How many a week? How many a month? And I could with my cheeks quite pink say well, I could think of three over the course of the last year and we saw thousands of patients. And so I realized something wasn't right. Just having that question wasn't enough. And we needed to look a little deeper about what was going on with the culture? What could we influence with the culture, staff and clients to make this a more comfortable place to talk about the violence in folks' lives.

A little test to give yourselves about your own program. I think in our programs we focus so heavily on other kinds of things that can affect pregnancy. How much time do you spend talking about how to do a glue cola test. How much time do you talk about other things when we know that violence is so much more likely to be occurring in this woman's life. We do the same thing around H.I.V. So I think some of that has to do with the comfort level of our staff and we really need to encourage more conversations about this to make it as comfortable for us to talk about the nasty things as it is the reality of many of these women's lives. Complications during pregnancy. No surprise, pre-term labor and infection. We know teens are more likely to miscarry and –

I think this slide is super important because I think when we are working with pregnant women, we want the best outcome for their baby. And so when we know that there are things that they're doing that are going to affect the outcome of this baby it can be really frustrating. It can be really frustrating when someone doesn't change their behavior. I know that was true even in my -- certainly among my staff. It's like we gave her all the information on smoking cessation and she didn't go to the program. We gave her the information on going through a substance abuse program and she didn't go, dropped out or didn't finish. And I think that -- I think that truly women do not wake up while they're pregnant and think how can I hurt my baby today? I don't believe that's what happens. I don't think they think I'll smoke three cigarettes and it will really hurt my pregnancy. I think the reality for women who have been hurt is that they need a respite from the hurt and so that some of these coping mechanisms they had before they got pregnant, smoking because you feel a little better and a little lift with the nicotine.

Using drugs and alcohol, are all part and parcel of what we need to think about again in terms of focusing on treating the symptoms as opposed to looking at the underlying causes of that. And I think through educating your staff about other things that can cause people to continue using harmful substances during their pregnancy that can increase their capacity for empathy and help them move a little bit away from that bad non-compliant thinking with clients to what else can we do to help her? I think it's worth noting simply because I know a number of clinics are also working siem -- simultaneously on depression there is a concurrence. Late entry into care. I think that there is so many that

needs to go on when we have somebody who is coming in late into care. We're worried about a lot of things. We're wanting to get her in for an ultrasound. Wanting to get her in for whatever other testing we can do before this baby is delivered. And I think, too, that many folks don't recognize that violence can be one of the reasons why she ended up being unable to come into care until the third trimester and so again thinking about how many questions we're asking there and different directions, getting at that answer I think can be really important in the third trimester.

The biggest reason to screen. We know that homicide is, in fact, the leading cause of injury-related deaths among pregnant women. I think that's something that folks don't know. When I share that statistic, generally, in fact I was here in the studio earlier today and so some of the guys in the back who are doing tech diligently even as I talk right now were asking me about what the presentation was going to be about and I said well this is one of the slide I was going to show and they all said what? Injury and killed by who? I said, their partner or boyfriend. And they were all shocked. I don't think that this information necessarily is even common within all your programs. And I think it can be a really nice way to frame the discussion of violence for clients. I know that sometimes when staff are just starting out screening, that they can feel like asking questions about violence is really invasive and if they can again frame it, frame it around we'll be asking you all kinds of things because we want you to have the best outcome.

We'll be asking you about violence every trimester. The reason why is because we know this is the leading cause of death among pregnant women and we want to make sure this

isn't -- that everything is OK around your partner and you get whatever support you need that feels scary or dangerous. It's not about her specifically but public education, generally. Another slide that I think is surprising to folks. I'll tell you a little story about this. One of the women that I have the opportunity to present with on this project and is a dear friend of mine is a woman named Linda Chamberlain who works out of Alaska and started the family violence project there. One of the things they did in Alaska. They had an opportunity to interview women not breastfeeding. It was why aren't you breastfeeding, what are the barriers? The number one reason, domestic violence. And so what -- again what we were thinking about and what was important around this is thinking about moms who are bottle feeding again not that they don't care about the best nutrition for their baby, we all know breastfeeding is best for babies but really thinking about maybe is this a place where we need to be thinking about is violence going on.

Why might breastfeeding be something she wouldn't want to do? Well, if you think about it when a baby is attached to you it takes longer to take the baby off your nipple and move them to the side than it would to take a bottle out of its mouth. But also for partners who are jealous and jealous of the attention that mom is giving baby and/or feel ownership over mom's body that this -- that the breasts are something the baby shouldn't have access to. That only he should have access to. In terms of implications for nutritional supplement programs we saw a couple things in our program that I thought were worth mentioning. I had talked a little bit about substance abuse and how folks self-treat that way. I also think people can use food to self-treat. When you're looking at a lot of big weight gain or a lack of weight gain I think we need to ask ourselves about the question of

violence. If you're in a difficult situation, you might be not in compliance particularly with dietary recommendations and eating large fries with extra ketchup on the side as a way to fix it sugar and carbs make you feel better in the long run. For someone losing weight.

A story from our program. We knew this mom was getting WIC. When we were asking her to do 24 hour diet recall we weren't seeing the food items we knew she was receiving from WIC. I said are you making it into the appointments? Are you having problems with transportation? We were able to uncover that, in fact, her husband was controlling the food and giving her basically whatever was left over in the refrigerator after he ate whatever he wanted to. Withholding food can be a way of controlling victims. Rapid repeat pregnancies. It's something we want to prevent. We know it's better for mom's body is to have a break and kids spaced farther apart is better for families to do that. When we thinking about the non-compliant client who got pregnant right away, we have to I think think about the third trimester education piece and looking at this issue around birth control sabotage and talking to her about how supportive her partner can be around birth control to help avoid that.

The escalation of abuse, I wanted to talk about this one. I know that some women don't come in for their postpartum visit and we focus heavily on screening in the second and third trimester but sometimes it falls off in the post partum period. Violence can actually begin after the baby has been born and may not have been going on while she was pregnant with the baby. And a colleague of ours, Jackie Campbell who works out of Johns Hopkins, had shared with me research she's been doing about interviewing women

who didn't come in for their postpartum visits. They were messy down there? That means there was forced sex and ripped and they were embarrassed and ashamed to talk about what was happening. So again thinking about are we limiting our questions simply to physical violence and, you know, we really should be thinking about talking about poor sex and sexual choices as part of screening particularly in the third trimester.

Parenting skills. I think this is super important. Moms who have been victimized by a partner are more likely to be depressed and report harsher parenting. So what we want to do in terms of an educational message here. Am I saying that moms who have been hurt by partners and have been hurt as children, we know there is a correlation there as well are going to hurt their kids? No. What I'm saying is they'll struggle probably a little more than the average mom and I think that in our HEALTHY START programs we have this really awesome opportunity to talk to folks about -- about what kinds of problem solving are they going to do when they feel really frustrated and like tossing Johnny out the window? And normalizing that experience of real frustration with parenting. We've all had it. I don't think there is a lot of room to talk about those realities. And I think that moms are especially worried about if they do admit that they're really struggling or frustrated or they don't know what to do or the baby won't stop crying and they're wanting to make this stop, that we -- that we create the opportunity to talk about this. It's normal to have those feelings and there is a question of what do you do with those feelings and help them come up with strategies about coping? Who are you going to call? Who is your support system? All those kinds of things. And no surprise, moms who are depressed and moms who are harsher parents, their kids have behavioral problems as a result of that. I think

this is something that a lot of moms and a lot of programs don't know and I think it's really important. I think that abused women tend to think that the abuse is simply happening to them and so while they might be willing to stay in the relationship or they might feel like it's the safest thing to do to stay in the relationship or what have you I don't think they recognize there is a powerful co-occurrence of incest and physical abuse of their children. This is an opportunity to educate moms if we take the opportunity during the prenatal and post partum period.

I'm just going to talk briefly about strategies because I have a few minutes left and then I know we're going to have an opportunity for questions again at the end so I wanted to make sure that anything that doesn't get covered here I touched on and you want more, please type in those questions. Based on what I had mentioned before, I think it's important to routinely screen at pregnancy tests once every trimester, during the post partum period and those working in the well child, super important to integrate screening for domestic violence into the pediatric setting. I mention those moms who aren't coming in their their postpartum visits are getting their babies in for the first shots and appointments. It's a missed opportunity if we don't screen moms at that point because it might be the only access she has to talk about that. We want to include information and I was just, as I mentioned in cook county, and I had suggested that while giving domestic violence information, intensive domestic violence information in a prenatal packet may or may not be the safest thing for a woman to take home.

Giving information about how violence impacts kids is something that both parents will be interested in and another way to get at giving mom information that this is a safe place to come if this is an issue to her. If her partner happens to find it she doesn't have to worry about retaliation. Two, because I know so many of you do home visits. It's so important. A lot of times in home visits we don't have the opportunity for her to be alone. She might have a mother-in-law there, a brother there, a sister there, and so thinking about, you know, utilizing the telephone afterwards. Not screening in front of anybody else. The reason why I mention that is any number of folks, when I've been doing these trainings, have described it's the brother that told the partner to hit her. It's the mother that told the partner to hit her, to put her in her place. So we can't assume anybody is safe when we're going into homes and talking about violence. And then lastly and then I'll stop here, the finding success. And I think working with victims of violence can be super frustrating because we want to help these women. That's why we went into this work, right? We want to give them the best information about nutrition and how to take care of their babies and getting in and taking their prenatal vitamins so when we screen for domestic violence and get a yes and she doesn't take that information and leave, I think some folks can get a sense of feeling discouraged and there is a couple things around this.

Number one, we know women are at highest risk of either hurt or murdered by their partner when they leave. For some women staying might be the safest option but I think also when we can support one another in our work around that success around the issue of violence is simply giving support and educational messages around what she can do, where she can go, that she doesn't deserve to have this happen to her, that she's not

alone, that this happens a lot and here are phone numbers is a success. I guess I want to stop there. And I -- the folks that you'll get to hear from next are from D.C. and it was actually our very first site visit. Linda Chamberlain had the opportunity to go out there and fall in love with the creativity of the women who work there. They developed a number of programs and their own experience with clients who are victims of domestic violence. I wanted to highlight their creativity and the love that they have for the women that they serve. And I wanted to turn it over to Pat to tell you a little bit about it HEALTHY START.

KIM GREENWOOD: Hi, everybody. Welcome from D.C. I'm Kim. I was one of the case managers. I'm going to tell you a little bit about healthy start. We're one out of 15 projects funded since 1991 and again I'm a nurse in the case management department and Healthy Start's main focus was to increase infant mortality in the district of Columbia. We have four core services or activities that make up Healthy Start's component. The first one is outreach and recruitment. Finding the girls. Then we have health education as another component and then we have the consortium, our advisory board and then we provide transportation for our girls to get to prenatal care. I can speak on the nurse case management. The case management piece which has to deal with nurses, family service workers, which are resource parents. They help us define and identify the resources for our clients to better give service. Then we have outreach workers which also help with the fathers of the babies or significant others and they're helpful, too. That's what comprises case management under our Healthy Start. That's us. Then now I'm going to go into the two cases that I have to present to you.

The format will be talking about the demographics of the women and then our assessment tools that we use and then the critical incident and then I'm going to talk about the interventions that we as nurses or the case management piece offer to our mothers. The first client is a HEALTHY START client A. Now, this mother is a 32-year-old female she is originally from the Caribbean, Trinidad. She has four children ages 10, 6, 3 years and 9 months. She's a single mother. She receives city-wide benefits meaning she gets the WIC, she gets temporary assistance for needy families or some call it aid for dependent children. She gets food stamps, medical services as well. Now, she isn't employed at this time. When we admitted her she was just receiving city benefits and her educational background was she had an high school diploma. Now, she relocated to Washington, D.C. from the Baltimore area and she had lived with -- the 10-year-old has a different father. The other three children have the same father and they've been in a relationship for seven years and that's the situation and that's over a seven year period. He did abuse her a little bit prenatally.

This mother client A is a happy going person. She welcomes you to her house and offers you things to drink even if the man was coming she'll be friendly. That will be a part of the jealousy and insecurity. Why are you talking to those people? You don't even know them. You need to be quiet. When I say that that's what I mean about his own insecurities. Whereas his mom which Rebecca talked about how sometimes the families defend him. His mom would say maybe your personality shouldn't be like that. Maybe you should be a little quieter or maybe be a little more withdrawn. Nothing wrong with my son. I just wanted to add that would piggyback on what Rebecca was talking about. Also I wanted to

go into the critical event with case A. The critical event happened on a Sunday after the mother came from church. It was like I came in from church and I feel like hitting you and she ended up having her glasses broken, a right black eye. He pulled some of her hair out and facial scars. And now this mother in case A called 911. She had already had two previous calls on the domestic occasions that happened with them. When she called 911 they removed her from the house and took her to a battered women's shelter with the three kids. The 10-year-old remained in Baltimore. So she just has the three kids in Washington, D.C. So they went to a shelter and then the police took him into custody because he had already had two previous calls on him, calls on domestic violence. Come to find out this father previously had a parole violation. So even though she stayed in the shelter for a month she was able to return back to her home in southeast Washington which is where we had been doing home visits.

I want to touch how a nurse case management team, how we can intervene. Because we admitted her post partum we have utilized assessment tools. You can go on our website where you can look at the tools. The tools are devised of four things. They're a depression screening tool where we ask the mother are you feeling lonely, have you had a change in appetite, do you think that people -- do you enjoy life? It's about 25 questions that we really kind of look at and they can rate themselves either on the high or low end as well as we do a screening. I mean physical abuse, has anyone beaten you during your pregnancy? Has anyone ever forced you to have sex with them? Have you ever had any gunshot wounds or contusions? Then we also do a drug screening where we ask about your partner, does your partner abuse drugs, have your parents abused drugs, did you

abuse any drugs prenatally? Those are the types of tools that we have to help us identify when we first meet the client what level they're at, you know? Are they feeling like they're healing or have they dealt with it before or have they ever experienced it? Those are done under case management and our protocol is set up to screen the mothers at the admission and then at the three month visit, six month visit and then at nine months as well as -- so when the assessment tools give you an indicator.

Then the next thing I want to talk about is she was very open and admitting to the physical abuse when we admitted her postpartumly. Nevertheless she went into the shelter for a month or so and we only could see her by telephone calls because it's confidential. Once she came out of the shelter and got back into her own home environment with three kids she was like great, come on by, he's incarcerated and been convicted. I would love to see you all. She feels happier. Her life has moved on. And a nurse was very helpful because we offer job recommendations to her. Now that he has been removed from the picture she felt like I can move on with my life. I don't want to remain on public assistance and the different things that the city is here to offer. Do y'all have any job training and she felt good about family service workers to link you to other agencies, other collaboratives. The 6-year-old is now going to school all the time whereas before there was some truancy issues. Sometimes he wouldn't come to school. You never know what the night before was like. The 3-year-old -- then the 9-month-old is able to be cared for in home because she has family from Trinidad to help her and then we as nurses were able to give her a recommendation and she's working at Reagan national airport in the cargo and baggage

section. So we can say that her life turned around and she's happier. Maybe it's because of security.

Where as case B is a bit of a different situation. We wanted you to know that the baby is fine and so is the mother. In case B, are we on that slide yet? OK. Great. Case B is a little bit different from case A, this is a 22-year-old African-American with only one living child even though she's been pregnant four times. She had three miscarriages. Now, were they related to any abuse? Possibly. She has not admitted to that yet and maybe that takes time doing home visits where they feel like they can be more open with us. She is unemployed and she's married to the person who abuses her. They've been married for one year now and her husband is from Nigeria. He is employed, though. He works as a chef in a nursing home and also at dominoes pizza. A little bit of background about the father. Again, this is a father that has parole and incidents on carjacking in Washington, D.C. And he has had excessive bills that have accumulated. Their rent is \$650. He has a history of substance abuse.

Alcohol and marijuana is his drug of choice and he has violation to his parole due to a positive drug screen. Again, we're doing the assessment tools and can ask, when we say does your partner abuse drugs the mother can say he smokes a little bit. He may drink on the weekends. When those urines are positive for drug screens and you're an parole that can send you back to do time. That's why this father kind of working two jobs and overtime and he's the breadwinner. To keep his job from being locked up because he's trying to turn his life around so -- but in the same instance he's very flipped out because

he's the breadwinner of the house. This mother B doesn't get any benefits because she's married. We're not going to give her aid for needy families because she has an income coming in from the father. And their apartment, they live in a nice two-bedroom apartment that cost \$650, different from case A where the mother was receiving section A and city benefits until she got on her feet and able to turn her life around.

So case B. Before the baby was born, the father is working, the mother is home and pregnant but living in somewhat of a crowded situation. Because it was herself, him and his brother in a two bedroom apartment. Two males and herself. Her educational background was also a high school diploma. Now, she only admits to two incidents of physical abuse. Again the facial abuse. Both eyes have been black over the physical abuse. No one has ever admitted to emotional or sexual abuse. Only to the physical. And this is the only within the one year of her marriage. She has never made any reports to the police. And the maternal grandmother, the client's mother is always her shelter.

When the abuse happens she'll stay with her mom for a weekend or a few days until things cool off and then she'll go back because he always apologizes, I'm sorry, it got out of hand. So stressed out with the job. Trying to keep our apartment in good standing. You have to forgive me. It will never happen again. So what we try to do in this case is provide intervention again was we saw her prenatally up to delivery so we used the same screening tools. Now different from this case, the four screens that we used, she tested positive. She failed the screening tools. She definitely felt domestic violence. Yeah, sometimes he's hitting me. Yes, I've been abused and bruises to my face. She also felt

the some depression. No, I don't always feel good about myself. I don't feel like waning -
-waking up. Because we did the screening tools from the beginning we were able to refer her to what we now have a program call parent infant development program where we have a several social workers that come and do home visits as well as -- they'll do depression screening and a whole evaluation in their office or at the client's.

So we intervene with these assessment tools and in talking to her you could see she was afraid -- when you asked her a question, her body language indicated somewhat -- some fear. So again from the referrals linked to other agencies so they could address her type of social issues. We did WIC and some of the other, you know, city wide agency. We offered her lactation consulting. Help with breastfeeding. Sometimes when you're stressed out your milk isn't going to produce. Are they eating? Why isn't your milk flowing? Why don't you feel comfortable holding the baby? So that has been helpful, too, from a neighborhood clinic. And then we also linked her to a nurse practitioner for OB care and GYN care which was very good in probing different questions. They took more time than sometimes we had in the clinic with the nurse practitioner.

Lastly we looked at job training. Job training, they meet the mother where she is. Even though she may have a high school diploma. Does she have good interpersonal skills to do an interview. Dressing to impress, you know, they have a clothing bank. That has been good. Now, the last question that I just want to talk about. A lot of people say why did she say and why is she still there? Y'all are in the house. Why is she married to him? She didn't call 911. She doesn't feel like the police need to intervene. He already has a

violation from a carjacking. I don't want to cause any trouble. When you go to their apartment it's very neat, clean and orderly. A beautiful apartment. Different from when we've done home visits where she has been abused and her mom's house in Washington. Her mom's house is not as neat. It's somewhat overcrowded.

Four adults living there and only one sofa to sleep on. So security is one of the reasons why she stays. Why wouldn't I want to stay in an apartment that is clean? I don't want to live with my mother. Where would I sleep? She doesn't have an income. She's not employed. She doesn't have a job right now. That's why we were trying to introduce her to the job market and lack of self-confidence and feeling that victim mentality, as well as she really defends him and strongly believes when he apologizes, he's not going to do it anymore. I hope it doesn't happen again. You know, you don't understand. He's very stressed out. He works all the time. He has to make this apartment look good. I want my baby to have the best of everything. I mean, it's OK. He's not going to do it again. He said he wasn't. And so she feels that the abuse sometimes is justifiable due to his extra stress from the working, courts, violations, parole and carjacking and all those different things. Kind of like a backlash to his anger. So again, we in case management our plan is getting use of her mother's house if an incidents happen again.

Motivate her educational level. Encourage her. You can get some refresher things and stay linked to the social worker. Helps them look at their parenting skills. They do developmental screening to see is the baby thriving and rolling over, responding, lifting their head. Are there any reasons that the baby is not thriving? As well as I want to link

them to the next one is Pat Parker where we have a concept that gives our clients a wrap around link of services as well. Pat will present on that.

PAT PARKER: Hello, everyone. Thanks, Kim. As Kim mentioned, there is a lot of support that is needed for our Healthy Start who are also not in HEALTHY START who are experiencing domestic violence. It's the mission of our project director to provide a model for our clients that would give them some emotional feelings of well-being and also to decrease the depression and the stress in the lives of some of the clients that we serve. So I'm going to talk to you about the HEALTHY START model, the house parties and give you a little background about where it dated from and so on as you follow the slides. First of all I want to talk to you about the -- the HEALTHY START clients. Some of the basic demographics of our client population. 97% of our clients are African-American. 90% are 22 to 25 years of age. Most of them are single. 71% are unemployed. High school or G.E.D. is the educational level of some of our clients and that's about 55%. And many have a history of depression and that is 37% of our caseload. 30% of them failed the depression screening so there was a great need for support. Some of them are at risk for obesity or are obese. They're smokers, some of them. Three or more pregnancies have been an experience and most of them have one to two children. Am I on target with the slides?

OK. Let's talk about the house party concept. It dates back to the Renaissance period. It is culturally relevant to many African-Americans. Let me tell you about the concept that

was dating back to that period. During that period, a lot of women had what is called house parties or/rent parties. These parties were designed for women to go to to increase their financial situations. They also served as a social event but even though they -- it seems that this was just a party, it was not just a party. Most of these women gained a lot of support from each other and that was really the reason that they kept going back. Because they were able to talk to each other about things that were happening in the home. It was a stress relief for them. Thus was the concept of the house party. Our house parties are not held in homes. They're held in community organizations and some of the community sites that we have staffed and to talk about their -- participate in the workshops that are developed for them. We are going to talk about how it works.

OK. OK. If you see how we made it work, you see it takes a village. Yes, it does. It did take a village for us. And at this time what I really want to commend the staff for the input and the assistance that they have given to make this model a success. Everyone, case management, the education and training component. The male outreach. Everybody was very, very helpful and also I cannot leave out outreach. Outreach and recruitment is a major, major part of making sure that these clients get to the party sessions. The accessibility is also a very important piece. Many of our clients experience problems with transportation or they'll say well, I don't have any way of getting there. So we wanted to make sure we can provide them the transportation to get them. We try to meet as many of their needs as possible. If we're not able to transport them, sometimes we give them tokens or fare cards so they can use public transportation if possible. Also, as I said, the staff input is very important. The staff buy-in is a very important piece because after

seeing the success of it, I think staff was able to see that it was really worth the while and really worth the time and effort that they put in to going out and recruiting. Making the telephone calls and listening to us say did you call them, did you get them to -- are they coming? Are they going to attend? So it was a very important piece and they have made it happen for each session. Partnerships.

Partnerships are very important because we have to look to some of our partners in order to hold these sessions in some of their offices or their places that they have services or will provide services. We have had a very good relationship with our partners in bringing the parties there and they've all thought they were very good. It was a very good concept and also made it a lot easier to have a place without -- a place to go for the house parties. The program should -- what is really important is that it's client driven. The clients had some input prior to the development of the curriculum because we held focus groups. Those focus groups did include input that was very essential to the development of the developmental stage of the house parties. We wanted to know what you need. We wanted to know how we can meet your needs. How can we de-stress you? So we got good ideas from them and some were used and to the success of that client. It is essential that the client knows that this is their time. So we try to provide childcare for them, we don't want them to be distracted.

Even though staff may come, they are there to provide the comfort for their environment and for that client. And so this is -- it is important for them to know that this is their time and for them to get as much out of it as they can. Each client is always -- is always

treated with respect and made to feel that she's very special. Lunch is served to her and again as I said, she also has -- does not have to deal with her children at that time and so I can imagine that she's feeling pretty good and very special during these house party sessions. OK. I'm sorry. OK, let's talk about the house party sessions. As I said, the focus of groups -- the focus of groups that were held gave us a lot of knowledge on use what we needed to do to develop for the clients. So there was a session that you see are how to manage anger, yoga and meditation, healthy parenting skills, pampering. Create your own action planned and I've talked a little about the last one added here. Family violence.

That will be a future session. I wonder if you can guess which one was enjoyed most? I think it was the pampering. The yoga and meditation, the objective was just to make sure that the women were able to understand the importance of being able to use yoga as a tool to decrease stress. Also, to look at the steps involved in the technique and things of that sort. They learned how to do positions and pretty much enjoyed that session as well. The pampering session included massage and aroma therapy and was very, very relaxing to them. We got a lot of positive feedback after the pampering session. The session on how to manage anger was a very -- the most important one, I think. And there was a nurse who came in to help women define what makes them angry, what makes them joyous and how to manage that anger and also talk to them a little bit about creating an action plan to help them through the process of managing their anger. Healthy parenting skills was something that was very helpful to them. I did at one time hear one of the clients say oh, I didn't know that when she was talking about time-out. The African-

American culture is not one who usually uses the time-out techniques. But it was introduced in the healthy parenting skills workshop and it was well received by that group.

Next slide. Follow-up and linkages. Kim talked a little bit about the follow-up and linkages. We use HEALTHY START case management team who identify some of the cases. Also, the Department of mental health is a resource for women who may need increased mental health intervention. The medical providers, MCO are also resources for follow-up and the community-based organizations and the family strengthening collaborative. The family strengthening collaboratives really focus on abuse and neglect. So that is an important link that we have and resource that we use to give these women the support mechanism as well. There is a high correlation between domestic violence and child abuse and so the family strengthening collaborative really provides the support that they need for the type of intervention needed there.

OK. Future directions. Where are we going with the house parties? Well, the house party -- we're now into our second round of the house parties and with the staff of the first model we continue on and we are getting great attendance and the future will include the males because we have found that a lot of the males have been positive for depression because we don't want to leave them out because it's an integral part as to why domestic violence has come into play in the home. So we will be including that model for the males. Also as you saw before, the domestic piece, violence piece will be added as a workshop as Rebecca mentioned, which we think is very important to focus more on that domestic

violence piece. So those are a couple of things that will be happening in the future. How is my time?

OK. Also, I wanted to mention that during the first phase of the house parties the goal was to reduce the incidence of depression and the sessions provided a supportive environment for the opportunity for information sharing and exchange and we want to expound on that and improve on that and what we plan to do is try to guide the clients to train them to be peer supporters. To be peer supporters of each other. So we are planning to train them to be more -- to be more -- to be more involved with increasing their skill level for parenting. Parents anonymous is an organization that we will partner with in order to train the women so that they can in the future be able to have the support groups on their own and meet with each other on a peer level. If there are any questions or -- I can assist you with any more information. You can contact me -- you can contact me by my email address which I think is on the slide. And I thank you very much for listening.

KAREN HENCH: Thank you, Kim and Pat and Rebecca for a very interesting presentation and we received many comments and questions from the audience. So I would encourage, you too, if you have questions to continue to submit them and right now I would like to go down the questions. One was a question of where can we receive more information about this? What is the website address of the family violence and are there any upcoming meetings?

REBECCA WHITEMAN: I actually think the lovely technical help that we're experiencing here at the University of Chicago can help with that. They have a slide on how to contact

us. But the way to go to our website is actually simple end abuse.org, 1-800-RX abuse. Our non-profit agency is set up to provide help around domestic violence and healthcare. That's what we're here for. Please contact me if you have other questions.

KAREN HENCH: Could you repeat that again?

REBECCA WHITEMAN: I could. You want to go on our website which is end abuse.org. The way to call us is 1-800-RX abuse. So that you can call and get help. So if you have statistics that you're needing help with. If you have specific questions around perinatal period or nursing curriculums or best practices for emergency room departments or pediatricians, we also have the national consensus guidelines on our website which is downloadable as well as the national consensus guidelines important the pediatric and adolescent settings which are a combination of helpful hints. How to screen protocols and then the back of both of those booklets are all these appendix that help you set up your practices to do this. We had the American medical association, ACOG, American academy of pediatricians all sign off on these tools so they're super helpful and current. They just came out last year. I did want to mention, too, we have a national conference every other year.

This year it's going to be in Boston, Massachusetts at the park Plaza hotel. The pre-conference is October 21 and then the conference itself is the 22 and 23. I'm going to encourage you all to register early because we know we have more interest than we have

slots. If you have more questions about the conference go to our website for that information as well.

KAREN HENCH: Another question that came in was what are the specifics on the ethnic diversity of those affected by domestic violence?

>> As I think we all know, domestic violence can affect anybody in any ethnic group in any economic group. I believe the latest statistic around which group might be more effected than others is Asian Pacific islanders. I'm not looking at those statistics. You should go to our website and/or contact folks in our office and they'll be able to help more with that. You can also go to the CDC's websites. They carry current statistics around issues related to violence.

KAREN HENCH: Also, if this is an interest in a future website, please put that in your comment, too, and we can go over some of the basic epidemiology of violence in a future webcast.

KAREN HENCH: Another question that came in and I'll open it up to the whole group is around pediatricians addressing family violence during well child visits. Does anyone know of strategies to encourage that to happen such as making an available service, providing training, so on?

REBECCA WHITEMAN: Is that one for me? In terms of a billable service, I can't answer that one. I mean, I think one of the things we hope to see -- there are a number ever -- of things bundled into well child visits. I would like to see screening for domestic violence is bundled in. When you're working with a managed care organization or some other body that creates those guidelines, I think this is a really important thing to bring up. Why don't pediatricians screen? They don't see moms as their patients, they see the kids as their patients. We know that again this is an Alaska survey information, but it's our experience nationally as well. That if you look across every discipline in medicine, the folks that are least likely to screen are pediatricians. It's a place we need to do a lot of work. I mention briefly that kids who are exposed to violence it absolutely affects them. One of the things I would love to have an opportunity to do in another webcast is talk more about that. I think that can be really important leverage for pediatricians. Did I answer all the questions?

KAREN HENCH: Yes.

REBECCA WHITEMAN: OK.

REBECCA WHITEMAN: I would like to comment on that also. Our program specialist who is providing support and training to some of our staff on domestic violence has a lot of educational materials and I happened to see her viewing a film for adolescents in the doctor's office but they were still under the pediatrician's care. They were not over age. Still seeing the pediatrician. And the pediatrician was questioning the young lady to determine whether domestic violence was going on in her social life in dating. Whether

she was dating someone that may have been abusive to her. So I guess I can't say whether pediatricians are really addressing it or not. There is educational material out there to speak to that issue.

KAREN HENCH: There absolutely are. If you go to our website we have the national consensus guidelines on screening in the pediatric and adolescent practice. So that information is right there downloadable, 92 pages. It prints out really pretty. If you're looking for that support it's there. As well as in a back section of that item there is also many other resources that also would help providers who are wanting more information from other sources.

REBECCA WHITEMAN: It strikes me, too, another factor is some of the research coming out that Linda Chanberlain covered as part of the P.A. on the changes that brain development during early exposure to violence but then also ways to improve that child's development later in life. That information provided to pediatricians would be a motivating factor.

KAREN HENCH: You know how you work in access. Is that on your website or would they have to contact you?

REBECCA WHITEMAN: The brain development information is not on our website. The researcher who has done the most work around this is a gentleman by the name of Bruce Perry, and you can also go to I believe Linda might have some information about this on

her website which is Alaska family violence prevention project. Go to that website as well. And you can Google it. I'm not exactly sure what the website address is but I know you can Google it and it comes up. Bruce Perry's work, there has been any number of articles talking about what happens when kids are exposed. And in fact their brains develop differently than kids who aren't exposed and it sets them up for a post physiologic and emotional problem. It doesn't mean that you're going to be completely impaired for the rest of your life but there will be things to work on and overcome. We do have these windows of opportunity and particularly around adolescents to help with kids who have lived in a horrific environment and witnessed violence. So Bruce Perry is the person to look for.

KAREN HENCH: Great. We've received a number of questions for Pat and Kim. One was do case managers complete the family violence screening for each client and if you can talk a little bit about your tools and depression screening tools.

>> Yes, we development like I was saying before. On admission of a client we do four screening tools. One is the depression screening tool. It was introduced to us by Dr. Phyllis sharp and it is called the Center for epidemiologic studies and it is referenced from RADLOFF, LS from 1977, a CES and D scale. A self-reporting question scale for research to the general population and it was under applied physiological measurement tools. And so that's what we used. It's a 25 question tool and the parent can add out of seven days does it rarely happens, never happens and we see one point or does it happen some days or a few days and then give them two points or occasionally or

moderate or most of all, for example, the first question is are you bothered by things that usually don't bother you? You can answer rarely or never and get a score of one.

Sometimes or a little bit and score of two or three, markedly or occasionally I do feel bothered by things that usually don't bother me or you can score points. We ask the 25 questions and then we subtract the four and if they get over a score of 20 then that's when sometimes we will educate that risk factor that they fall below average.

We have another abuse screen and go to our email address and we can attach it and send it to you. The abuse screen has two shapes where they can indicate if they have any thing like punch or kicking, the hand, chest, arm area, which extremity and it asks questions like have you ever been emotionally or physically abused by your partner or anyone important to you? You just answer yes or no. The physical one is only a five question and it asks at the end are you afraid of anyone surrounding you. Has anyone ever forced you to have sexual activity or some lady will elaborate more. The other screening tool we call it the four P's. Have you ever -- for key questions, have you ever used drugs or alcohol during your pregnancy, ever had a problem with drugs or alcohol in the past. Does your partner have any problem with alcohol and drugs, then the fourth piece of the fourth piece do you consider your parents to be an addict and alcoholic. The question is yes or no but that gives us the opportunity to expound on it if the client wants to elaborate a little more or give it more expression. At admission we'll do the screening tools if time allows. If it doesn't allow we'll go back within a week or two-week time and do an assessment tool. For most of the time today it looks complete with the one admission.

>> I would like to add to that, that all of our staff have been trained to administer the test to the client. It could be done before the client even reaches the case manager. And they also receive the tools during their case management time with us. So it's a plus that even sometimes when women come in just to be tested for pregnancy that's the time they can also be tested for depression or domestic violence.

>> Can you give us your website address?

>> Oh, yes, I can. Patricia.Parker @ DC.gov.

>> Another question that came in is why is domestic violence increase during the postpartum period?

>> I think it's something that I mentioned so I'm afraid I either misspoke or maybe only a portion of it got heard. What I said was it can -- domestic violence can increase or begin during the postpartum period. It can also disappear at the postpartum period. What we're wanting to do is broaden folks' thinking about when to do screening. I think historically we've been very focused on while the baby is inside of her versus after a baby is born and because we know it can begin then, we know it's so important to continue screening at that time.

>> Just to add to that, if you look at various studies that were conducted, for some women it is less during pregnancy, for some "Increasing Your Program's Capacity to it increases

during pregnancy and for other groups it may increase during the postpartum. There isn't any specific time. It's pretty much person dependent or situation dependent so I would agree it's important to screen not only during the prenatal period but also the postpartum as well.

KAREN HENCH: Rebecca, do you want to add to any other tools for screening for violence other than the ones used.

REBECCA WHITEMAN: If you go to our website there are other sample tools. I think the big thing, I think when you get comfortable with it you end up -- correct me if I'm wrong. But don't you end up finding the words that will best fit with that client? I really encourage folks to think about many different ways of screening. For some people using framing questions like I used as an example before. Because we know homicide is the leading cause of death among pregnant women we started talking to everybody about this. For some people given where they are in their relationship and maybe they see something, you know, can you tell me a little bit more about what happened, you know, with your hand. I see that somebody -- I see that you've been burned and I'm kerpd im-- concerned about that and I know women are hurt by their partners in pregnancy. There are different ways of asking and the most important thing is being genuine and comfortable hearing the yes. As I said, there is a really good examples in those tools on our website.

>> I just wanted to add, to the contact information. I wanted to add also that Diane Davis can also be contacted for any additional information that may be needed for the house parties and Diane's information is Diane.stages at dc.gov. She's our project director.

REBECCA WHITEMAN: Did you have any more questions you wanted us to answer? I guess the other thing in terms of the work I've been doing and visiting sites. There is more and more interest in including fathers in programs and talking about how we can better help them be parents, etc. And I was just actually in a training in Boston with a child witness to violence project that Ms. Groves runs and you can go to their website and find some wonderful things and tools there. One of the things that they've been recently working on is this issue of fathering after violence and in interviewing a number of men -- let's back up. In interviewing women who are victims of violence, what they want are the men in their lives to have good relationships with their kids. They don't want to cut them out of their kids' lives. They want it to be good and healthy and that mirrors what they want in their own relationships with them. They want the good stuff to stay and the bad stuff to go away.

In terms of working with the dads who are the perpetrators, no surprise that the perpetrators have not all that much empathy for their partners. When you incorporate that information about how their kids have been affected, that seems to turn on a light. And I, too, think we've been focused very heavily in this conversation around women who are victims of violence. What I've heard from a number of HEALTHY START programs are women are also perpetrating violence and a number of workers -- I see nodding there.

This is actually something that came up in D.C. I'm going to -- I'm not a victim because I hit him back. I'll hurt him before he hurts me kind of thing. So this idea of talking about the impact on kids for moms who are also perpetrating or in the process of doing some self-protection physically engaging with their partners is another really effective tool that I would like to see more people sort of engage in and talk about. Hopefully that's one of the pieces that can come out of this is thinking about how we use kids and there are a couple posters, actually, that I've given out to a number of the sites and you can get off our website as well that specifically focus on the effects of violence on kids. The physiologic, emotional things and also that during pregnancy and the post partum period abuse can escalate and affect the baby. It's another way to get that message out to moms and dads in programs and in your clinics and in your HEALTHY START.

KAREN HENCH: Unfortunately we've run out of time. We have gotten a few more questions in and they're all about topics related to this that we can talk about. Dating violence, violence in young women and teens, fatherhood programs like you mentioned, Rebecca. Supporting the staff who work with clients, who are victims of violence. So these are topics of interest to you. Please include them in your evaluations so we can plan future webcasts. But on behalf of everyone here I want to thank you very much for tuning in to this webcast.

>> Bye-bye.

>> Bye-bye.