

***U.S. Department of Health and Human Services  
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**Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program  
Technical Assistance Coordinating Center's**

Webinar

***"Intimate Partner Violence, Part 2: Empowering the Home Visitor"***

April 29, 2014

3:00pm Eastern

Presentations by:

***Linda Bullock***, PhD, RN, Associate Dean for Research, Univ. of Virginia, School of Nursing

***Cynthia Zagar***, MSW, Program Director, MIECHV, Michigan Dept. of Community Health

***Rebecca Levenson***, MA, Health Consultant, Futures Without Violence

***Pam LaHaye***, CFLE, MIECHV Coordinator, Maine Families, Maine Children's Trust

Kathy Reschke: Thanks so much Robert. Hello everyone. It's great to be with you today. On behalf of the MIECHV Technical Assistance Coordinating Center I want to welcome you to our second webinar on Home Visiting and Intimate Partner Violence: Empowering the Home Visitor.

If you weren't able to join us for Part 1 last week watch your email box. You'll be getting an email later this week with several follow-up resources including a link to the audio recording for last week as well as this week.

My name is Kathy Reschke and I'm the e-Learning Coordinator for the TACC. And I will be your facilitator today.

As most of you know the TACC is funded by HRSA and staffed through ZERO TO THREE and our partners Chapin Hall, AMCHP and WRMA.

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The TACC provides different levels of support to MIECHV grantees including these webinars using ZERO TO THREE and partner staff along with many expert consultants and in coordination with our other TA providers.

So just a quick logistical item before we get started on our topic, because we are using a phone line rather than your computer for audio all of you are automatically muted which means you can hear us but that our presenters cannot hear you; however, we do want to know what's on your mind.

So share your comments or questions any time during the webinar use the control panel that's to the right of your screen. At the top of the panel is an orange arrow. If you click on that arrow you can show or hide the panel. And at the bottom of the panel is an open text field where you can type your questions or comments.

I'll be monitoring the question box and we'll either respond to your question or comment or pass it along to our presenters during our Q&A period.

To start off today's presentation we're joined by Kevin Bates. And Kevin is the HRSA Project Officer for Regions I and II. So Kevin thanks so much for agreeing to join us and getting us started.

Kevin Bates: Thank you so much and good afternoon everyone and thank you for joining today's MIECHV TACC webinar.

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I think many of us would agree that most home visiting programs target families deemed to be at risk for adverse outcomes.

Depending on the study approximately 15 so about 45% of families enrolled in home visiting programs report intimate partner violence.

Within MIECHV we truly understand the link between violence and adverse birth outcomes. For example the legislation requires that grantees demonstrate improvement among eligible families participating in the program in six benchmark areas.

One specific area is reduction in crime or domestic violence. Empowering the home visitor to understand the nuances challenges they will face when conducting intimate partner violence screenings is critical as we strive to demonstrate improvement among eligible families.

In order to most successfully achieve this overarching goal and improve overall maternal and child health home visitors should be better trained and empowered to assess for intimate partner violence and to provide discreet and safe assistance to women experiencing abuse.

We're looking forward to the presentation today and the discussion as we explore this important topic.

Now I'll turn it over to Cathy to continue our discussion. Thank you.

Cathy Bodkin: Thank you Kevin. I appreciate everyone joining us for Part 2 of our discussion about home visiting in the context of intimate partner violence.

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I just want to remind everyone that we're considering intimate partner violence as the physical, sexual and psychological harm by a current or former partner or spouse which can occur among heterosexual or same sex couples. We're not considering the broader domestic violence issues but just the IPV issues.

And we know that this is of great importance to the home visiting not only in the outcome measures but also just in the process of - for providing the program services.

Last time we went over identifying critical partnerships in the community that would help the families overcome and learn new skills related to managing of anger and other strong feelings, also looking at cultural variables and differences in providing the program in rural or urban settings.

And we looked at how the state system can promote screening and different MOUs between agencies and how that for instance might assist in developing a community system.

In today's objectives we're looking to increase the understanding of the challenges encounters specifically by the home visitor in conducting those screenings and in continuing to provide home visit team services to families where intimate partner violence is a risk factor.

So our agenda today is that we will have three presenters. And you have a packet that was sent to you in the registration where you'll have their full biographies. We have Linda Bullock and Cynthia Zagar and Rebecca Levenson.

And following that we'll have a Q&A session; we hope that as you're hearing these presenters and the discussion that follows that you will type in your questions. We want this to be a webinar

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that is most useful to you and we know that there have been a lot of different questions raised during the past couple years about the process and purpose and of screening and then what happens with referrals and ongoing visiting. So we hope you'll join us and type in your questions as we go along.

This diagram should be familiar to all of you. It's from Implementation Science and some of the previous materials that we've shared with you. We hope to look at this from a slightly different perspective today.

I want you to consider today how leadership, competency and organizational drivers might support the work of the home visitor who's working with the family at risk for intimate partner violence.

What happens when you have partnerships with several organizations such as DSS, health, childcare, domestic violence shelters, and each has goals or definitions of success? Some of these might carry mixed expectations of the home visitor and the screening process and the resulting referrals.

The home visitor may be caught in the middle perhaps a lonely place, perhaps an uncomfortable place to be, so we wonder how does the organization assist the home visitor over time, how can the community support the home visitor's efforts to foster healthy family relationships?

And what can the system do to sustain the family and the home visitor?

It's not a simple system and especially when you have multiple organizations and are trying to have an integrated community early childhood system.

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So now it is my pleasure to introduce to you Linda Bullock who is currently the Associate Dean for Research at the University of Virginia. She will be followed by Cynthia Zagar who is the Program Coordinator for the Michigan Home Visiting Initiative, and then by Rebecca Levenson, a Health Consultant for Futures Without Violence.

Linda I'll turn the program over to you.

Linda Bullock: Thanks Cathy. It's a real pleasure to be with everyone this afternoon.

What I'm going to be presenting are two studies that we have run at the University of Virginia, University of Missouri and at Johns Hopkins University. This is in a partnership.

So on the next slide you'll see I think everyone - again yes, everyone received the article, Eddy-Kilburn article about the Town and Gown.

And in this study we learned some important things about insights into the issues that we face when screening and implementing for intimate partner violence in the home.

So hopefully our work from the DOVE-1 Study and then I'm going to briefly talk a little bit about our newest study which we call DOVE-2. Hopefully these findings can help home visitors and administrators and achieve today's objectives for the webinar.

So next slide, early in the DOVE-1 Study we had a real aha moment. We realized that there was a BREP, a problem in recruitment. You would have thought that intimate partner violence had completely disappeared from Baltimore and Missouri alike despite that in other just recently

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conducted studies we were getting about 35% of the women we were intervening with were experiencing intimate partner violence.

So in Missouri we hypothesized that maybe one of two things could be happening. First of all, was it an issue that women were not disclosing abuse because of the rural nature of the Missouri site?

Many of the home visitors that work with women out in rural areas, they know each other. They go to church. Their kids go to school together. So maybe the women were not disclosing or was it also that maybe the home visitors simply felt uncomfortable screening for intimate partner violence?

So as you can see one of the last training workshops that were sponsored by the Missouri Department of Health and Senior Services, we decided to take the opportunity to investigate what the home visitors were really feeling. What were their comfort levels? What were their attitudes?

So first of all we conducted a paper and pen, completely anonymous survey looking at the home visitor's attitude, knowledge and belief. And then in the same training session we also helped focus groups with these same home visitors asking them questions.

So what I'd like to do now is just report some of the findings of this workshop investigation so to speak.

So there were 23 home visitors that participated in the survey. And as you can see out of this slide 9 out of those 23 or about 40%, almost half of the home visitors had been - admitted to abuse at some point in their life.

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And when you look down at the age, years, education, everything was very similar. The only thing is that those admitting to abuse may have had more training which might indicate that actually these are the women who were willing to admit to the abuse. They were more sensitive to the issue.

So we might even be just looking at the tip of the iceberg here.

So in the next slide you'll see across the top we ask about physical, sexual and emotional abuse. And then we ask whether it was experienced during childhood. It was witnessed in childhood or did it occur during, you know, in their adult life.

And out of the nine people you can see that who had admitted to abuse. Many of them had experienced many forms of abuse over their lifetime.

So the importance of these survey findings to administrators I think first of all we realized that home visitors are just real typical of many other groups of women. Many of them will have been or currently victims of abuse. And the important thing that we realized from this study is that any training that we do with home visitors around this issue we must start with the acknowledgement that many women will have a history of abuse.

And then our individual agencies need to develop policies to address how they're going to help these home visitors deal with their own violence histories. This is I think critical for us to understand as we go forward with this issue.

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So next, let's - let me just share with you some things that we heard from the focus groups because in my opinion it's through learning from each other that we're really going to succeed in helping home visitors and helping the women that we serve.

So one of the first questions we asked was what is like to work with women who are experiencing intimate partner violence.

And I'm sure that none of these responses are going to surprise people. I think many of you probably have the same feeling.

First of all, you know, they talked about being helpless to find solutions. And/or not having any resources, feeling responsible for the women, felt fearful for their own safety.

And one of the things that we heard a lot was difficulty in holding a balance between the caring of - be caring and professionalism.

Then we asked about what were their fears of initiating the screening. And many of them talked about just making a fool of themselves; not knowing what to say. Also the fear of stirring the pot, would they cause more problems.

There was a lot of issues about when was the best time to initiate the screening, being careful not to be judgmental.

And then something we heard over and over again of fear of what to - what would happen if the abuser walked in.

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Then we asked well what do you feel would be the repercussions of screening and intervening.

And again not having resources to refer women to, not knowing what to do. Is it fear that it may tear down the relationship or they lose the client in their caseload; the fear of increasing her harm and then again that back to what if he walks in while I'm doing that.

Then we asked so what are some of the successful strategies that have been used to intervene.

And we heard building relationship rapport and trust with the woman, bringing up the whole topic of intimate partner violence casually in the conversation.

And I think you heard a lot last week about how to talk about healthy relationships and going from there as to how the women feel their relationship. Is it healthy?

Using nonjudgmental body language, I think this is one of the most important things. Another really important thing for us to realize is that women know when we have our phony detectors on and can detect this immediately if we're not really interested in really hearing what she has to say.

Educating her on normal relationships and then showing respect.

So after - at the end of the workshop then we asked the question has this sort of a workshop changed your practice. Do you think it will change your practice?

And many resoundingly we heard that they were really rethinking about stirring the pot and decreasing their own fear. For many of them they were placing their own fear on the women and

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realizing that they had to come to grips with their own fear if they were really going to help the women.

They - we also were able to provide safety measures that they could use if the abuser walks in such as having pamphlets in their bag that they could pull out. And talk to the man about being a better father.

And the increased cephalization that the very outcomes that they were trying to achieve they now realized that their own fear was going to put that in the way of achieving the outcomes that they wanted that they had to address their own fears about intervening and screening and intervening in order to achieve the outcomes that they were hoping to get through their home visiting.

So in conclusion I think the two most important things that we realized in this - on this slide is point number two that IPV training for home visitors is essential but it needs to be ongoing. We can't expect that one training is going to address the home visitor's own history of a violence and working through that and then coming to the realization of what they need to help the women change.

And then bullet number four for administrators that might be on the call today, I think, you know, you cannot give up and just say well this is too hard. Let's put this all in the too hard basket about screening and intervening. We just need to keep trainings going and working with the home visitors, providing that listening ear when they come back and they hear terrible stories.

So any kind of transition to something new is going to take time. And we just have to give it time to work.

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As far as the DOVE intervention itself we know that many home visiting programs use other screening tools and other interventions.

But for us the DOVE intervention that we were testing was shown to be very flexible. It could be implemented in a variety of home visiting programs. We actually were in a Nurse Family Partnership Program as well as other less structured programs such as the Missouri Community-based Home Visiting Program and the Baltimore City Health Department Home Visiting Program.

And in those two programs there were home visitors that had a variety of different educational levels.

So the DOVE intervention isn't something that requires a highly educated person to deliver. It just requires somebody who has the training and has been able to work through maybe their own issues to be able to deliver it.

So the next thing I'd like to talk to you about just briefly is a study that we have ongoing now. We have a fellow from the UK that is a visiting fellow from the UK that is doing some qualitative interviews with people who are participating in our DOVE-2 Study which DOVE-2 is taking the intervention, the screening tool and the intervention from DOVE-1 but using mobile health to test whether using mobile health in the home is more effective than the paper and pen screening.

So she's done so far 32 qualitative interviews. She's done them in Baltimore, Missouri and Virginia. These are the areas that are participating in the DOVE-2 Study.

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And she's talked to home visitors, managers, social workers, administrators and women who are actually in the DOVE-2 Study. Five of them were randomized to the tablet group, eight were - are in the randomized to the paper group.

And the questions she's asked them is what have been the successes, what have been some of the challenges, and what strategies are - you used to overcome the challenges.

And I wanted to share the - some of the results with you because I think this really again helps in understanding the challenges encountered today by home visitors and also some of the awareness of administrative and supervisory community supports that are needed.

So one of the first questions she asked of the home visitors is what do they see as their role in responding to the intimate partner violence. And what she heard was, you know, challenging the myth - helping - and these are actual quotes from home visitors.

Educating women about what is normal and not normal in relationships. Counseling them on what is a healthy relationship. They also see - saw their role as someone for the women to talk to.

And she heard many of these women don't have someone to really listen to them. Reducing their isolation, keeping the women and children safe, many home visitors saw this as their role to help her through that path of being safe.

Orienting women to sources of support and practical help and repeating the messages. She heard from home visitors that some stuff just doesn't get absorbed by the women the first time. So it needs to be reinforced.

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When she asked the women about their experiences of being asked about IPV which, you know, very little research has been done from that angle. What do women think about being asked in the home?

And what she heard from the women, and this was one that really surprised me, was the lack of awareness about resources, she heard from many of women I didn't know that they had an abuse help line because if I would have known that I probably would have been able to call it a lot sooner in my life.

So this is one important thing that home visitors can do by intervening in the home.

When she asked about the tablets, women did seem to like that. They thought it was a good idea that the - as one woman said, "I think it might be a good idea because there's some things that you just feel ashamed about."

So hopefully maybe the tablet can be used to screen for sensitive information not only about IPV but maybe depression and some other things.

And then when - never - another woman or women talked about, never talked about it before being asked by the home visitor and I thought that this was something really important." she could tell that I was a little bit upset." This is after the woman had used the tablet to answer the abuse screening question "because like I said, I've never told anybody. I never talked about it ever at all."

And with me if I'm upset I like to talk most of the time about it. And I think she could see that and it made me feel a lot better. Just like a weight was lifted off my shoulders."

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And this is something we have found over and over and in our research study is that the important thing is opening the door to communication. We found that the women did not get upset by us screening and intervening for intimate partner violence. And in fact they actually welcomed that the door to communication was open.

So continuing on how the women felt about being screened, they liked talking to the home visitor. They thought it helped. They got relief and comfort from it.

They felt like it also was de-stigmatizing about the violence. Yes. Because a lot and this is talking about home visitor screening, “yes, because a lot of people don’t think that stuff like that happens a lot. And in reality it happens a lot. It happens more than you think it does.”

And I think with women talking about it, it becomes more of a real thing. And then identifying patterns of abuse, for many women by home visitors talking to them about the abuse they are able to recognize the patterns in their own lives.

So this one woman, “said it’s the same questions over and over again. So each time the questions were asked I realized it’s the same stuff that I’m continuing to experience” with her partner even though we’re not together. “The pattern has never changed. It’s the same answers I’m giving because he’s not changed and it’s helped me to see that. It’s more visualized when you’re answering the questions than when you just think about it.”

So in our studies we repeatedly asked the women about the abuse. And to this woman that was really helpful in her own life.

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So next is that women's experience of being asked what they thought helped, one, they thought establishing a trusting relationship. They - was essential in doing that.

And then the challenges that the home visitors discussed with us was feeling comfortable and gaining that confidence which I think we've heard from many home visitors. Finding the right time to ask, encountering resistant women and keeping women safe.

So strategies that other home visitors thought that worked well was depersonalizing and raising awareness of how common IPV is among all women, avoiding the term domestic violence or intimate partner violence during the initial introduction of the topic so again going back to last week's webinar, talking about healthy relationships.

Ensuring that the woman is seen in a confidential environment, if it's not - if her home is not a valid option, then maybe in the home visitor's car, at a clinic, somewhere that it's comfortable.

And then being aware of the abuser's whereabouts so arranging a convenient time when he may not be in the house.

So this is some of the results we received. And I look forward to your questions after the completion of other people's presentations.

But now I'd like to turn the mic over to Cynthia Zagar. Cynthia.

Cynthia Zagar: Thanks so much Linda. I love listening to your work. It just so much mirrors the work that we've done here in Michigan. So it's really fascinating to know that we're kind of following parallel paths.

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So in Michigan we began to look at data collected by our evaluation partners, Michigan Public Health Institutes, over a year ago.

And during that initial review of the data the State Continuous Quality Improvement Team noted that sites were not completing the screening tools that were required to assess substance abuse, depression and domestic violence for the MIECHV Initiative to the degree that we expected.

Upon initiating the Plan-Do-Study-Act Cycle the do phase involves supporting home visitors in becoming more comfortable with the subject matter by providing them with additional training. Not necessarily exclusively on the tools but also on becoming more comfortable with the subject matter which can be very hard to have conversation about even in the best of circumstances.

It was our hope that in doing so that home visitors would then feel safer and more confident to implement all of the screening successfully.

In order to conduct the training's in a relatively short amount of time we piggybacked the training effort onto the Association for Education of Young Children Conference that takes place here every April. It's one that many of the home visitors could have already had on their calendar so we felt that it was really the perfect opportunity to have the training happen relatively quickly.

We were able to tap into local experts who were happy to offer their input and guidance on the subject matter and we were also able to offer the two day training free of charge and we also were able to provide them with free continuous education units for social workers and educators.

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Specifically with regard to domestic violence component of the training the presentation was adapted from the Futures Without Violence materials to help home visitors to learn more about the widespread risk for experiencing domestic violence and also to understand how to help families to be safe and to get resources necessary to facilitate a long term separation from the abuser.

It was the intention of the training to really support the home visitors in assessing their own comfort level in talking to families and in helping them to understand the impact not only on the person who's the target of the abuse but also the impact on pregnancy, infants and young children.

So fast forward to the next slide and to early 2014, now we're about ten months, post-do phase of the first cycle. Our data was now indicating that completion of all the screenings had increased which we thought told us that our first project was successful. But our data was also showing us that was a very limited number of positive screens for domestic violence.

In starting our second Plan-Do-Study-Act Cycle we looked at the national averages for identification of domestic violence and noted that the rate that our sites were reporting was significantly lower than even the lowest national estimate. And this really parallels the work that Linda talked about earlier.

The CQI Team crafted the problem statement of across MIECHV Programs in Michigan very few women are identified as needing services for domestic violence due to screening process.

Knowing that the initial cohort identification rate was only 4.5% led the group to initial Aims Statement of by September 30, 2014 14% of female caregivers in cohort 2 served by the

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MIECHV funded home visiting sites who are screened for domestic violence by 12 months of enrollment will be identified as a need of domestic violence referral.

All of this information was included in our team charter which was a part of the resource packet that you should have received from Lena last Thursday.

The team charter supports us in staying on point about what we're looking to impact. It identifies who plays what roles on the CQI Team and it helps us to stay in tune with what we actually have the power or authority to influence so we don't start going down a path that we ultimately wouldn't be able to do anything about.

Continuing our work in the plan stage of our current project we conducted a force field analysis to identify possible factors in place that would be working for or against the positive identification of domestic violence.

Some of the reasons that the team identified that we felt may be helping home visitors complete the screening accurately were the fact that they were actually not doing the screening, the fact that all of the models actually conducted supervision with the home visitors and the fact that the data about the screening completions were being fed back to the sites.

With the next slide I can talk more about the actual process. We noted that some of the restraining forces that we felt could be impacting the lack of positive screens included home visitor experience, training and general knowledge about domestic violence statistics and the implications of that on their work.

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Ultimately in looking at this information nine main categories were identified and from that a questionnaire was developed to further explore with home visitors and supervisors their own impressions about what might be impacting their outcomes.

The questionnaire was also included in the resources email that was sent out last week.

We felt that was important for us to get a deeper understanding of these things from the local implementing sites so that we could more accurately move forward and identifying the root cause.

Questions on the survey included what training has your home visiting program received on domestic violence?

How do you help the participant feel comfortable answering honestly?

Does the tool you use to screen for domestic violence make sense for participants?

How confident are the home visitors in using the screening instrument?

And how does supervision support the domestic violence screening process?

We wanted to ensure that we were looking at a broad range of things that could be impacting the completion of the screenings and didn't want to assume that it was exclusively the responsibility of the home visitor. The questionnaire helped us to look more broadly at the entire system that should be in place to support the home visitor.

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The results of that survey were presented to the group. And from there we developed an interrelationship diagram to help us to determine of potential root cause by brainstorming possible reasons for the problem. And then assessing which idea caused or influenced each of the other ideas.

The interrelationship diagram outcome led us to identify the possible driver or cause of the problem as being training and the primary outcome for improvement being the capacity to address domestic violence through service provision.

Knowing that we had already attempted training to impact the screening process we didn't want to end the identified cause there. It appeared to us at this point that positive identification has a learning curve. And it may be more complex than a one hour training could solve.

Our next step in the planning stage led us to completing an affinity diagram by identifying what needed to be included in any training provided in order to impact more accurately identifying domestic violence.

Some of the overarching themes in completing the affinity diagram included strategies for home visitors to use upon identifying domestic violence, the screening process itself and interpersonal competencies and skills.

During our next meeting with the CQI Team we're going to be taking a closer look at those training topics and determine next steps in moving towards the do stage of the cycle.

All of this is a story in the making. I think probably the biggest takeaways from our work so far is the importance of recognizing the level of supports that home visitors need to do the work and

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that there are ways to get back on track if the train has gotten derailed in a way that is empowering and validating for the experiences that home visitors have in the trenches.

So our next speaker is Rebecca Levenson who's the Health Consultant with Futures Without Violence. Rebecca.

Rebecca Levenson: Hi Cynthia. Thank you so much and thank you to Linda and thank you for - Cathy and Kevin for creating this opportunity and for partnering together to make this webinar possible.

For those of you who weren't on the webinar last week I'm just going to quickly mention Futures Without Violence because I think it's an awesome resource and something to sort of hold in the back of your head is that anything that gets touched on or that got touched on last week, if you think ooh I would like to know some more about that.

Go to our web site and chances are there's a slide set, there's a poster, there's a something there that might be able to help you with an issue that you're having related to intimate partner violence or children exposed to violence in your work or maybe your partners in the field are looking for information there as well.

Futures Without Violence houses the National Health Resource Center on domestic violence. And that means that we're charged with creating guidelines, policies, protocols, tools for healthcare providers in the field.

And as you can see in the query you can see sort of a sampling of some of the tools that we've developed so we like images of happy and healthy kids. And we really think a framework to hold

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the issue of domestic violence is one that and Linda Bullock mentioned, is really about what's possible and healthy relationships and safe relationships and how we help families get there.

And as we go to the next slide, I wanted to highlight a tool that we developed specifically for home visitation.

And you heard Cynthia mention this in Michigan, they adapted the curriculum for their staffing. And for those of you who have not seen the curriculum here it is, Healthy Moms, Happy Babies.

And again this is something that's available. You can download it off the web. We can send it to you as a hard copy and I'll be talking about some of the additional tools that come in a kit if you order a hard copy as we move forward.

So basically in this curriculum it's very much home visitor centric meaning that we did a couple of things when we put it together. First of all, my colleague Linda Chamberlain and I went to 32 different Home Visitation Programs over the course of a couple of years and did a lot of interviewing as Linda described in her qualitative research.

We talked to home visitors. And we separated them from their supervisors and we said so how is it going. If you're asking about domestic violence tell me about how you're really asking and tell me about the screening tools that you use or do you not really use a tool.

So we just we wanted to hear from the horse's mouth in a way that would say, what was going on so that we could create tools to support them in what they needed to do.

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And this curriculum was developed to help with the need, the latest federal benchmark around domestic violence specifically.

So one of the pieces of research that we highlight and we - there's a number of stuff that we highlight throughout the curriculum is of course Linda Bullock's study and that's on this next slide that she just talked about in great detail.

And again we were looking both to research to best practices to experiences in the field to really help home visitors to think about how to create something that would best support home visitors. And again you can see here are some of the barriers that Linda talked about in the queue.

So what we did was we took on this research and we said okay, well let's create some ways of creating space for conversations as we do training. And develop a tool that other trainers can use so that folks don't have to reinvent the wheel.

And so I'm just going to give you a quick example of that. If we were live, if I were standing in front of the 100 odd of you that are on the call today, I would ask you this first. I'd ask you a question about this first statement.

So I'd say okay, so I want a show of hands, true or false. Starting and ending conversations about difficult or stigmatizing issues like domestic violence can be challenging during home visits. Is it true or false?

And again if we were live almost everybody would have their hand up and say true.

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Now take a look at this second statement, again true or false. We take care of ourselves by presenting questions and educational messages in a way that feels most comfortable to us.

So I do it one more time. I want you to kind of think a little bit about this. We take care of ourselves by presenting questions and educational messages in a way that feels most comfortable to us.

And with that question I will tell you or that statement, the audience is usually about 50/50, half of the folks will say that's true. We do that. And the other half will say that's false. We don't do that.

So I'm going to sort of get to the nitty-gritty of that in just a second.

And I think one of the reasons that that's such an important thing to sort of bring up as a topic is because I think that the issue of a staff exposed to violence is something that we're just beginning to fully understand and Linda talked about it in her qualitative research. You know Cynthia has had some conversations about this as well in Michigan but this issue about, what are the staff exposure - what does the staff exposure to violence look like?

And the question that I would ask you all again if we were live is does your program currently have a protocol to directly address how to help an employee who's experiencing domestic violence.

And chances are a lot of you would say no. And I think that one of - and then some of you might say well actually we have an EAP Program. We have an Employee Assistance Program. And I would say that's awesome that you have an Employee Assistance Program.

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Do you by chance know if there's expertise around the issue of domestic violence if one of your staff are experiencing domestic violence.

And I will tell you again. Typically the answer is I'm not sure. I don't know. We've never asked that question. That's an interesting question.

And so really this is about helping folks think about where we begin the work with domestic violence and making the argument that in fact we have to begin with staff as we move forward into doing better work with clients.

And there's a really important reason why.

So as we come to this next slide, I think the way you introduce the screening tools you use in your program no matter what screening tool is, whether you're an NFP program or you're a Healthy Families America Program or you're a Healthy Start Program, all programs that I've worked with for 15 years and I love you all. I love home visitors.

But I'll tell you. I hear from home visitors across the board how they introduce things that make them uncomfortable that to go back to what Linda was saying, if it's a situation where they're worried they're going to hurt the relationship with the mom because they're asking something too personal or maybe they are in it themselves and it's too triggering to get a yes, the way you introduce it matters.

So these are some real perks from home visitors in the audience when we asked them about how they were handling using screening tools. And this is - these are quotes from a training I just did in Washington State a couple of months ago.

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So here's what one home visitor had to say. And I'm again asking them how they introduced the tool." I'm really sorry to have to ask you about so many personal things like about any domestic violence in your life."

Now whether that home visitor and I'm sure she was well-intentioned and she was warm and she was lovely in the training site, I can imagine she's just one of those compassionate beings, I don't think she knew that in the way that she asked that question she was looking for a No answer.

And we look here again at the next quote from the home visitor." I mentioned I have to do all these lame forms for the state and this is one of them."

Again what message does that give to the mom in the program?

And I'm not faulting that home visitor at all, right, because I think these are training issues. I think these are programmatic issues. And I think these are systemic issues. And I think by bringing them out in the open that allows us to sort of work through them.

So what if there were a different way to start the conversation that made the issue of domestic violence safe for staff and clients?

And again this is building on what Linda talked about and certainly something Cynthia is grappling with specifically in Michigan in her CQI process.

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For those of you who've not seen this safety card this is the size of a business card. This is part of what comes in your toolkit with the curriculum. And you can see there's a new baby on the front of it and a mom looking really happy about kissing that baby.

And it's all about, right; it feels good to look at that image. It's a happy image. It's what's - it's about hope and possibility.

And I want to tell you this is a fab - this is a slightly older version of the card because while we were working with home visitors in Maine because again we listened to the field, they say hey Rebecca if you take off creating futures without violence on the bottom of that panel or the card and just say Healthy Moms Happy Babies, you know, a dad wouldn't even necessarily know or a perpetrator would never know that that was something about domestic violence. They would just think it's another one of those mommy baby tools.

So I say that to say there's all kinds of wisdom that have gone into these safety cards and they are evidence-based over many years and that. So when you get your new packet that creating futures without violence will be off of it.

And the way we introduce this card and that's on the next slide is essential to the conversation starter as well. And again this is through lots of qualitative interviews with home visitors with understanding the needs of clients and here's how we train providers in the field, home visitors in the field to use the card.

We started giving this card to all of our clients for two reasons. In case you might - it might ever be useful to you or so you know how to help a friend or a family member if it's an issue for them.

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It's kind of like a magazine quiz. It talks about safe and healthy relationships and what to do for ones that aren't. It has hot lines on the back and it gives certain steps to keep you safer.

So as Linda said there's no mention of this is a card about domestic violence. We very much frame it in the healthy and safe relationships.

And as you look through the panel of the card the very first one is kind of about how is it going and are you treated kindly in your relationship, are you treated with respect sort of helping folks who maybe never had the opportunity to have a safe and healthy relationship outline for them what they deserve.

But the second piece of this that's really important is that it's much easier to hand somebody something that has I think a happy image on it as opposed to a hard image or a sad image.

And the piece about offering this as something that can be helpful to the mom but also something that can be helpful to her sister, her auntie, someone in her family, her best friend was the breakthrough.

And we've again done lots of qualitative interviews around the safety card. And we have a paper that's coming out about a study that we've done in a reproductive setting related to safety cards with survivors of violence.

And we specifically asked them about so do you remember your provider telling you that piece about something to help a friend or a family member.

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And everybody did. And they felt like it was really empowering. So the piece about the home visitor entrusting a woman to be somebody who could help others we believe also helps a survivor who may not be able to come forward.

In terms of additional tools for your programs, again I want to turn you onto things that exist in the world and that are great. I love this tool. It's free. It's downloadable. It's called a Trauma Informed Organizational Toolkit.

So every Program Officer who's on this call, every state MIECHV Director, every Program Coordinator or Program Manager the things that I'm talking about in terms of well what are the steps, like I want to help you figure out how do you create a Trauma Informed Program for your staff.

And again you don't know what you don't know. So this really walks you through things to think about in terms of are educating your EAP Programs and, you know, are the folks who you refer to, your mental health experts, your substance abuse experts, are they all on the same page with the intersection between violence and how it might be affecting these other outcomes that you're working on at MIECHV.

It walks you through things to consider to make things more supportive as supervisors to home visitors in the field.

And so home visitors who have had a trauma experience result it helps a program really think about how to best support the needs of those folk.

So I think that's just a really good resource. And the next slide is just a last thought here.

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Now we've talked. I know for your programs that in fact the goal for the domestic violence benchmark is to see a reduction in domestic violence.

And I just want to say based on what we heard from Linda and what we've heard from Michigan that in fact I think we need to rethink that piece of it. Because as programs get better at doing this and this is what I heard from Michigan and it's exciting to hear states coming to this realization on their own through their own data. As they get better at this we're going to see an increase I hope in the number of positive disclosures and not a decrease necessarily.

So moving to the very last slide, just quickly for folks who - for folks - moving to the last slide just because I know we need to get to Q&A - for folks who are interested in these safety cards or other pieces connected to the toolkit you can go to our web site.

And with that I'm going to stop and turn it back over to Cathy so that we can get to your important questions, comments and ideas. And I just really want to thank everyone for their time.

Cathy Bodkin: Thank you very much Rebecca and Cynthia and Linda. I'm going to turn it over to Kathy Reschke to coordinate the Q&A section.

And please write in your questions. We want to be responsive to what your immediate concerns are for those of you who are on the phone.

Kathy Reschke: Thanks so much Cathy. Yes. Now it's the time when you get to ask your questions of our presenters.

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We've also invited one of our presenters from last week to join us, Pam LaHaye from Maine, works with the MIECHV Program there. And so she's also available to respond to your questions as well as Cathy Bodkin.

So we have a wealth of wisdom experience and experience for you to tap into so don't miss that opportunity.

For the Q&A segment I'm going to be drawing from questions that you submitted during registration as well as questions that you submit now during this time. We'll get to as many of the questions as we can.

But if we don't get to yours don't dismay. We do have a plan for that and we'll talk about that at the very end of the webinar.

So go ahead and type in your questions and while you're doing that, I'll go ahead and ask one that was asked during registration, actually several people addressed this issue so we'll - we framed a question around it.

So Linda had mentioned during her presentation that the emotional impact on many home visitors just of working with women experiencing intimate partner violence especially if they've experienced abuse themselves.

As one of you wrote in during registration I think one of the most difficult issues for home visitors is understanding how the trauma associated with intimate partner violence can affect the working relationship with clients.

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So I wondered if you panelists could talk more about the impact of the situation on that relationship.

And Linda I wondered if you would begin that conversation.

Linda Bullock: Thanks. Yes. I think, you know, what I hear from the field working with home visitors and if they've had past trauma, it can impact them in a couple of different ways. I mean I think for some women it helps them to actually help with other women but for many women it triggers the PTSD of their own abuse.

And I'd like - Rebecca mentioned the trauma informed care. And Rebecca would you mind maybe expanding on a little bit of that because I think this is what we need to help those where the violence actually gets in the way, their own personal violence gets in the way of them working with other women.

Rebecca Levenson: Thanks Linda. I'd be happy to and, you know, this is a topic that I'm really passionate about. You know when I go and do trainings I often speak as a survivor and I'm pretty out about my own story and sort of the fact that I get triggered when I do training's or when I, you know, am out in the world doing this work. It's just the nature of the beast.

And I have funny stories about how I manage as we're- again doing - slides right now you would see a large box of French fries.

And I say that because my colleague Linda Chamberlain and myself, we've developed the curriculum and have done all these training's all over the place. At the end of every full day

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training that we do we go out for french fries and we go out for Lemon Drop. So it's all about comfort, right. It's about comfort.

And we both have rules around the kinds of things that we need to do to take care of ourselves.

And what that sort of - what our french fry ritual really did was help us figure out that there were some places where staff needed to see their truths and as I think supervisors needed to really debrief the staff about how things like coping mechanisms and ones that maybe weren't. And, you know, to address some of the staff burnout stuff because we know when folks are more supported you have less staff turnover. And when you have less staff turnover, you have a richer program that's able to do more with moms and kids. So right, it fits that we want to do this as a way to support our programming.

And so there - as I said there's a number of tools on the Futures web site. But one is a slide series on a Trauma Informed Practice. And there are a number of tools to support supervisors in doing that.

And I would strongly suggest that every program gets a book if you don't already have it called Trauma Stewardship.

And what it does is sort of keeps that my funny thing about french fries, make me feel better and I feel fine about having them after a long day of talking about hard things.

And she manages to look at the issue of PTSD and look at triggers and look at a trauma response in a way that is kind and compassionate and offers opportunities to have larger discussions with your staff.

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So I just want to say that there's a lot out there to support your work and we look forward to hearing the kinds of questions that you have about other tools that would be helpful to your programs moving forward.

Cathy Bodkin: So Linda this is Cathy. One of the messages really is for home visitors to have self-care routines and for their supervisors to help them develop those. They may or may not feel comfortable disclosing any past history to supervisors.

But what's important is for the supervisors to support them having healthy self-care. We could debate whether french fries are healthy. But I'll accept that they are.

Linda Bullock: Absolutely Cathy. I think, you know, having someone to come and debrief with is really essential.

And administrators need to be aware of this and make time in their schedule to make sure that they talk to each of their home visitors about how it's going. I think, you know, the role of the administrator is crucial in this particular area. Administrators need to be supportive. That screening and intervening for intimate partner violence is so very important because it affects the very outcomes that they're trying to achieve.

But also they need to be supportive to their home visitors. So supportive of the idea of screening and intervening but then the sort of on the ground support as these home visitors go out into the field.

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Rebecca Levenson: And the one kernel I want to leave folks with really is what you just said Linda because I think that's right, is we often hear that there's just not time to do that or my home visitor in a rural state or in a frontier state I might not see them for a whole month so how I can check in with them.

And we really have encouraged the field to think about the use of conference calls and setting a time that's sacred where you can't ever slot in a home visitor where maybe it's 4 o'clock on Friday afternoon that there's going to be time to debrief either as a group or as - with a supervisor and an individual so that that isn't lost. And really build that in.

So that's an active strategy that we've seen be very successful in programs starting to make this part of their routine.

Cynthia Zagar: I think what's interesting about what both of you have said just now, this is Cynthia, is the fact that your stories just mirror the experience that I've had in actually working with sites here in Michigan.

One of the ways that we're able to support sites at least, we hope it's supportive to them, is to actually go out and talk to them about how things are going.

And during one of my recent visits to one of our implementing sites I had an opportunity to talk with one of the home visitors about her work.

And in talking with her one of the things that was on my radar was this information that we were getting about limited number of domestic violence screenings being screened as positive.

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And so in my conversation with her I started to ask her about how she implemented the screening herself and she proceeded to tell me about this amazing way that she introduced the topic. She shared with me the questions that she asked. She really shared very passionately how she really sat with the women that she was asking and was really with them in their experience.

And what's interesting is that just even in hearing about how she did it was very moving.

And as we continued to discuss about her methods about she implemented the screening she did share with me about her own experience of being a survivor of domestic violence.

And subsequently also shared with me about the work that she had done to work through that. And I just found that really fascinating that here I had someone who, you know, had had this experience and one of our worries would be that they would really struggle. And as Rebecca shared that, you know, you have the possibility of PTSD experiences which may or may not have been true for her.

But what I do know is that the way that she was able to talk about this with families was just really magical if I can just put that word on it.

And I kept that conversation in my thoughts as I drove back to the office. And immediately got on the phone and called our evaluators.

And I asked them can you check and tell me what sort of feedback are we getting from this site? Are we getting a greater amount of positive screens?

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And sure enough, it's really this particular site has a significant amount more of positive screens in domestic violence than across the board of all of the other local implementing sites.

And so again I just think it really speaks to what both Linda and Rebecca, you've talked about this afternoon.

And I just wanted to share that experience of it being real and in the field.

Cathy Bodkin: That's Cynthia special. And I think Cynthia and the idea of having the comfort to and patience to not rush through a screening, to - but to give time and attention to just hear what the woman is saying and to be patient.

And I think sometimes we go through a check off of getting the screening done to get the data entered rather than what's the useful intervention which is the patience and the listening.

Kathy Reschke: I'm going to turn our direction to another question that was raised by many of you during registration. And we've had a couple of questions come in just now on the topic of mandatory reporting, home visitors sometimes reluctance and even fear to report intimate partner violence for a number of reasons either them - safety of the client, the woman in the home, fear, her own fear as a home visitor but also maybe a reluctance of, you know, breakdown of that relationship between the home visitor and the client.

I wondered if one of you would want to begin that conversation about that sticky conversation about mandatory reporting.

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Rebecca Levenson: This is Rebecca. I can briefly speak to this. One of the modules in the curriculum is dedicated to the issue of mandatory reporting. And it gives some helpful scripts so some ways of introducing a conversation about need to report in a trauma informed way so how for example if you have to report Child Welfare and that's going to make mom really afraid that, you know, about what's going to happen. You can offer for the mom to sit with you while you do that, etcetera, etcetera.

But I - before I sort of launch into that piece I want to mention something that again you - Cathy you started - you ended with which is a staff person's own fear.

And I think that again if we want to be really successful in helping our home visitors to do the best they possibly can around this issue of families we want to start with them.

And I think that there's real fear for a lot of folks and legitimate fear in some cases of working with the family and having a situation come up or having a perpetrator show up when they don't expect them to or seeing a pair of shoes by the door and knowing that there's somebody else probably in this house that maybe they can't see right now and they've heard that things are hard in that woman's relationship.

So that piece of it and the policies that are in place around staff, the - and really doing that with the staff upfront I think again grease the wheels for them feeling more confident in having those conversations with family.

And then the other piece I just wanted to mention in terms of the mandatory reporting is that, you know, the - I know every program is required to talk about the limits of confidentiality. But the how you do that specific to domestic violence I think really matters whether it be putting them at ease

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because everyone's - most states are afraid that you're going to have to report any positive disclosure of domestic violence to Child Welfare and that's often not the case. In fact with most states that is not the case.

But home visitors may have some misconceptions there so again for supervisors I think really being clear about what the guidelines and laws and rules are around this really helps them in terms of having that anticipatory conversation with moms around if we find this out to be true here's what we have to do including nothing other than, you know, provide support and referrals which is the case in many states.

So I'll stop there.

Linda Bullock: And Cynthia I don't know if you - I'll jump in. It's Linda. Again I would echo everything that Rebecca has to say. I mean I think the whole idea here is that, you know, we're working with the women and partnering with them.

And that partnering means that, you know, we don't do anything without her knowledge and that we work together on these issues.

As far as losing the clients, I just - I do not think that that's a valid fear. Well I don't think that that happens that often. I think the women, what we're seeing just time and time again, the women appreciate the door to be open for the conversation as difficult as that conversation might be. I mean yes, women might, you know, cry during the conversation.

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But that can also be healthy that she's able to get out her feelings and express her feelings and not holding them inside. So I think, you know, we have to be prepared for where the woman is when we're discussing this. But if she knows that we're her partner that is a real strength.

And I'll stop there and maybe Cynthia you or Pamela has something else to add.

Kathy Reschke: I think, I think Cynthia got dropped or she - I just got a note from her that her phone cut out so hopefully she'll be able to join us back again in a minute Cathy.

Cathy Bodkin: Yes.

Kathy Reschke: But Cathy Bodkin did you want to add some comments?

Cathy Bodkin: Yes. I also want to say that I got dropped out of the webinar so I'm trying to get back in so...

Kathy Reschke: Good thing we're just in the Q&A and all is that - there was was that slide that says Q&A so.

Cathy Bodkin: Yes. So I think, you know, one of the things that's important to convey to the home visitors as well as what Rebecca said which I'm glad she clarified some of the legal requirements and where is the mandatory reporting, is very, very few states require mandatory reporting of the intimate partner violence.

And but the area that the home visitors working in is really the - focusing on listening with the parent, the home visitor, I mean the mom or could it be the dad that was being abused as well.

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And helping them think through what are some of the constructive choices? What are some of the changes that they want to see, you know, in their home and in the relationship with their children and with their partner?

And that that just opening up and talking as we've seen from Linda's research just and the comments that Cynthia made, just doing that is an intervention that has incredible ripple effects and changing what happens and what's possible that for many of these people they have not seen another possibility.

And so, you know, this is not to feel as though you have to take care of all of it but identifying some boundaries for the home visitor about what their role is. What are reasonable goals to expect?

And that listening is an intervention going back to what Rebecca had as success is that it reduces isolation and creates some options for safety for everyone in the family.

Rebecca Levenson: I think...

Kathy Reschke: I wondered if anyone - oh go ahead.

Rebecca Levenson: Sorry. This is Rebecca. I think, you know, Cathy it's cute that you highlighted that slide. I think that one of the other things that helps home visitors feel good about the work that they're doing is to truly understand what success means.

And I love that you and Linda and Cynthia all of sort of tied back in this idea of listening.

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You know most women will not necessarily ever go - will not go to shelter at some point in their lives, most will not. A very few do.

And I think that when we step out of the mindset that A equals B equals C so if I identify or if she identifies their experiences and I get some of these referrals, success equals that she goes to shelter or success equals she leaves that relationship.

And I think like with substance abuse or mental health issues, right, relationships are complicated. The dance around how we work through those things is complicated.

And what folks really need is support from home visitors around where they are in a story as opposed to where we would like them to be and I sometimes call survivors pocket people. You know I just kind of want to wish I could take them home and sort of fix it, right.

And I think that that when we can talk about that as a group and as a supervisor you can really raise the bar around folks understanding that and giving them permission to talk about frustration but also celebrate that that mom has been able to take whatever little that she's been able to take around safety or supports for herself and her child and that's really awesome.

And I guess there's all kinds of ways we get to measure success and, you know, I'm just going to call on my friend Linda Bullock right now and ask if you'd be willing to share that amazing story that I got to bear witness to in Washington, D.C. with one of the home visiting nurses that you brought to that meeting in DC some years ago now.

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Linda Bullock: Right, right. Well I think you're talking about a program that we worked with DOVE-1 Study. And again these home visitors went through all of these different almost phases of being, you know, comfortable with screening and intervening in the home.

And this one particular home visitor testified on Capitol Hill for us was talking about how she actually accompanied. Ended up accompanying a woman to a shelter support group that was a nonresidential support group for battered women and how that really just changed her life being there in the support group with the woman, changed both of their lives I guess.

Rebecca you may remember more of the story than I do but I just - with how this home visitor was just so touched by taking, you know, putting this woman in her car and actually taking her to the support group.

Rebecca Levenson: Well I guess that it lends itself to and it was an incredibly beautiful story and there wasn't a dry eye in the audience.

And what the home visitor realized is that there were more doors that were available to her around providing support then she had initially I think realized.

And so when we think about safety, planning and support, I think what she did and again I know that there are different limitations in programs and some programs allow you to transport, others don't. And I understand this is complicated.

But what was so cool about it is that she had offered this referral a number of times just that there's a drop in support group. It's for moms or in relationships like yours Thursday nights or whatever it was.

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And the mom had refused, refused, refused. And then one day the home visitor say hey, would you like - would you - how would you feel about like maybe if I just went with you?

And that was the turning point. And that was the magical, you know, sprinkle of, you know, that was going to make the difference for that mom because she loved and trusted her home visitor.

And I think she figured that if her home visitor was willing to take her maybe the place wasn't so bad. And it really provided I think a lot of opportunities for that particular nurse who was a home visitor to influence her colleagues and program.

And that was another thing that was just really, really exciting to hear about is how that one person's experience took over I think that program and then the state's programs. Because I think she probably spoke at the statewide programs and then all of a sudden there she was in DC testifying to Home Visitation Programs nationally. And it was something pretty cool to behold.

Kathy Reschke: Thanks so much for sharing that story both of you, very powerful. I do want to turn our attention to a couple of other. Make sure we get a couple of other issues that were raised by a lot of people before our time runs out. And it's going quickly.

The first one is really about the struggle that many home visitors have expressed that they just have a strong desire to help get the woman and her children out of the situation and yet struggle with how to motivate them or, you know, are frustrated when they don't see the client taking any action. I just wondered is how would you - would respond to those common thoughts and feelings of frustration, not knowing what to do, not feeling like you're seeing any progress.

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Cynthia I wondered if you would want to start that conversation.

Cynthia Zagar: And those are really great questions because it is just so common for that to be the home visitor's experience.

And I just cannot say enough how critical the process of reflective supervision is for the home visitors that are working with these sorts of situations. Any time we go into a home and we're experiencing feelings like you're describing of being frustrated, that the person is not ready to make a move or is not taking action that that home visitor thinks should be done, those feelings get expressed in ways that aren't even detected by the home visitor.

And so it's just so critical that the home visitor feels that they have a safe place to take those feelings. And to be able to process them and work with the supervisor about working through them, about what that frustration is like for them.

And so reflective supervision is just needs to be an ongoing regular part of home visiting for these sorts of situations.

And I guess the other thing that I would add here is that any time you're working with any family that is experiencing any sort of trauma at all it's relative to that situation as well.

Cathy Bodkin: I think that's such a good point Cynthia. This is Cathy. And I - the importance for the supervision and the agency policies themselves to recognize the - whether it's the amount of what someone carries or the resources that Rebecca talked about being available to the home visitor in terms of stress management or EAP.

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I think what's interesting on the IPV screens, domestic violence screen that we do is that it's quite different from the depression scale. We don't help home visitors plan out what are the different levels, what are the varied responses one could have to a positive screen because each of these families is so different.

And identifying the strengths, identifying what the resources are and the family and the community and having a variety of plans that keeps getting reviewed with the supervisor on these cases and then really checking in for the health and welfare of the home visitor and how they're coping with this. It is a real community support of the home visitor as well, and so how to get others conveying similar messages?

But I think the depression - with a depression screen people are more understanding. One thought I had too was there are some programs that have been able to connect with mental health consultants that can go into the home with the home visitor to make that first connection.

And for then the mother or the parent be willing to attend counseling following that once they've met the person so that would be another bridge.

Rebecca Levenson: And I think to piggyback on that Cathy the other - beyond the mental health provider who might be able to come into the home, we strongly recommend deeper partnerships with Domestic Violence Advocacy Programs. And we've seen success where advocates with the permission of the mom were able to come into the home as a different way to sort of support what was happening with moms and kids exposed. And that was a really important strategy to help her get to another place even through utilizing a great resource.

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Kathy Reschke: Well thanks. We've got time for one more question and I'm going to throw out one that probably needs a half hour to talk about so that's really not fair to you but it's one that a lot of people have raised. And again a couple of people raised it already during the webinar.

And I'll just quote from Alison who wrote. In many cases the abuser is the biological father who's present for at least some of the home visits. Many visitors do not attempt to include him in the activities because they know about the domestic violence history.

What strategies might help home visitors feel comfortable engaging fathers to strengthen their skills when appropriate?

Who would like to take that?

Linda Bullock: Well I'll start. It's Linda. I know that this has happened many times in the homes even when we're there doing our research work.

And again I just want to emphasize that, you know, one, talking to the mother beforehand and having a plan is really important so that we're all on the same page to know that if he comes in what's going to happen or if this isn't even a safe time for us to be there that or to be in the home that she feels comfortable with even a code word saying, "No, this isn't a good time."

But as I mentioned earlier we always kept brochures and because we do want these fathers to be good fathers. And if he should walk in the room immediately diverting the attention and saying, oh I am so happy you've walked in now. You know you've come in because I was really hoping to talk to you about fathering and, you know how to be a good father or even if it's developmental,

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you know, whatever, you know, educating him and making him feel that he is, you know, a part of the conversation is a way to deflect what you're really doing with her at that moment.

The other thing that we found is that if we weren't able to get in any screening or intervening talking to the woman asking her to help carry out bags because notoriously home visitors are always like the bag people carrying lots of bags, carrying those out to the car and then just even taking that brief moment as you're walking towards the car or having pamphlets or something in the car that you can say could you come out and get these pamphlets. I forgot to bring them in.

So there are ways of working with women in the home.

I'll let somebody else. Maybe they have other ideas.

Rebecca Levenson: Well this is Rebecca. There's two things. One is I think we need to develop MOUs with community partners. That can be a great strategy. So maybe you're having a hard time getting mom alone but maybe when she goes for her OB follow-up or maybe when she takes her child to the well child visit or maybe you offer transportation for those two visits so you can do that but in the car or by phone are strategies that we've had folks use.

But to highlight a tool that I think has been really exciting around engaging fathers and I think empathy works that around exposures to violence and how it affects kids as a way to again talk about healthy families and healthy relationships. Talk about how their own experience, that father's experienced as a child in their home of origin. How the mom's experience of violence in her home of origin can affect parenting. That there's strategies associated with that.

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So to flip it around and say hey, we're doing this as part of our program. We have a - teachers have the really new and great safety card that looks at adverse childhood experiences to use with moms, grandmas, dads, any of their caretaker in the home.

And I think it allows for home visitors to get some of those universal messages we want for families and we want but through the lens of children. And I think that makes a lot of sense when we're concerned about perpetrators because we know that one of the things that really makes a difference for perpetrators to look at themselves differently is stronger sense of empathy, self and others. And it's through caring about their children that I think we can tap into that.

So that's another little tool that I wanted to mention and another place where you can engage fathers around a conversation around healthy families and healthy relationships and what we want and tools to help dads without it being about domestic violence though.

Kathy Reschke: That sounds like the perfect place to wrap up even though I hate to stop the conversation because there's just so much good stuff being shared.

But I like being able to end on such a positive note Rebecca so thanks.

And thanks to all of you presenters, all of those of you who shared your expertise and your wisdom and your experiences. Really appreciate the time and effort that you've invested in preparing for the webinar and engaging in conversation around these really difficult questions.

So before we bring it to a close we have a couple of other items to mention. And we've had some problems with the slide so I don't know if we can advance or not. We may not be able to so you'll just have to use your imagination. Ah, there we go.

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First thing I wanted to mention was upcoming webinars. Next month we've got - are going to be wrapping up our series on Systems Integration by Focusing on Evaluating Your System Integration Efforts. Then no webinar in June but in July we are going to be having another webinar.

And we're still very early in the planning stages but I can whet your appetite by telling you that the topic is going to be on using data so go ahead and put that on your calendar and then look for an invitation.

On the next slide you'll see if you're not already familiar with the MIECHV Newsletter. You'll want to subscribe because in the June issue we're going to feature responses to some of the questions about intimate partner violence that we didn't have time for. See, I promised there was an answer to that. So everyone's question will get answered. But you have to be a subscriber so subscribe if you haven't already.

And then one final request. Please do take time to complete the webinar evaluation that you're going to be receiving soon from WRMA. I promise you we not only read those responses but we depend on that feedback to improve our TA efforts.

In the next couple of days you should also be receiving a follow-up packet in your email that will have additional resources so you won't want to miss that.

I'd like to acknowledge our Senior Case Specialist Cathy Bodkin for all of her hard work in planning and producing today's webinar. Special thanks to Lena Cunningham and Tracey

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Harding and the rest of the TA Team at ZERO TO THREE for making today's webinar happen and for keeping it happen in spite of technical issues.

So thanks again to each of our speakers and thank you for joining us and for all that you do for the wellbeing of children and families. Have a great day.

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