Healthy Moms, Happy Babies:

A Train the Trainers Curriculum on Trauma Informed Domestic Violence Programming and Practice

Second Edition

By Linda Chamberlain, PhD, MPH
and Rebecca Levenson, MA

FUTURES WITHOUT VIOLENCE®

A Train the Trainers Curriculum

PRODUCED BY

Futures Without Violence

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TABLE OF CONTENTS

Appendices

Bibliography

DVD: Addressing Domestic Violence in Reproductive Health Programs: A Video Training Series (Downloadable)

INTRODUCTION

The first edition of ***Healthy Moms, Happy Babies*** was developed in response to the Affordable Care Act, which was passed in 2010, and included provisions to support the America's Healthy Futures Act. This act was a $1.5 billion dollar, five-year national initiative to support maternal infant and early childhood home visitation programs. In addition to providing funds to support these services, the legislation also included new benchmark requirements for states. One such benchmark requires home visitation programs to measure a reduction in "crime or domestic violence."

This curriculum has been updated to help your home visitation program meet the federal benchmark to address domestic violence.

Futures Without Violence (FUTURES) has been working with home visitation programs and providing domestic violence training and education for more than 15 years. We have developed a second edition to ***Healthy Moms, Happy Babies: A Train the Trainers Curriculum*** in response to the barriers that states and providers have experienced in regard to the federal domestic violence benchmark. This edition was created to better support state agencies and home visitation programs in developing a core competency strategy and to ensure that all home visitors have adequate training and resources to help women and children living in homes with domestic violence.

The curriculum provides training, tools, and resources to help home visitation staff address the complex and sometimes uncomfortable issue of domestic violence. When it comes to promoting health and safety outcomes for women and children impacted by domestic violence, there is a methodology to effective assessment, primary prevention, and anticipatory guidance messaging during home visits. What one says and how it is said—whether by direct assessment or through universal education—matters and can make a difference for women and children living with domestic violence.

Home visitation professionals need education about the impact of personal and vicarious trauma to do their best work with families and reduce the amount of staff burnout and turnover that some programs struggle with. They also require simple and effective tools to support assessment and conversations about healthy relationships and domestic violence. This curriculum provides such tools to support assessment and education through the use of scripts and safety cards during home visits. These tools have been designed to facilitate safety planning and supported referrals to domestic violence programs.

FUTURES is committed to further developing policy and public health responses to domestic violence and reproductive coercion. Our hope is that every home visitation program will integrate this curriculum into their core training and programming to support safe and healthy families, and create futures without violence.

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Dr. Linda Chamberlain, an epidemiologist specializing in the health effects of domestic violence on women and children, is the founding director of the Alaska Family Violence Prevention Project and a consultant for Futures Without Violence.

Rebecca Levenson, a former Senior Policy Analyst at Futures Without Violence is now a consultant for Futures Without Violence. A nationally recognized speaker, she has worked extensively in the area of reproductive and perinatal health within community clinics and home visitation programs for the past 25 years

About the National Health Resource Center on Domestic Violence

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

For free technical assistance and educational materials:

Visit: www.futureswithoutviolence.org/health
Call toll-free (Monday-Friday; 9am-5pm PST):
415-678-5500
TTY: 800-595-4889
Email: health@futureswithoutviolence.org

HOW TO USE THIS TRAINERS CURRICULUM

This curriculum has been designed for home visitation programs and is focused on developing staff skills and broadening staff's thinking through interactive exercises and activities.

While this curriculum has been designed so that other trainers can use these resources to conduct training independently, Futures Without Violence staff are available for direct training and technical assistance to model how to use this curriculum and how to develop a plan for sustainability and quality improvement for enhanced domestic violence programming within home visitation and case management programs.

!

The curriculum includes:

- Overview of how to use the PowerPoint slides, instructions for training, exercises, and directions for small group activities
- Companion downloadable materials which include participant handouts, assessment tools, and video clips

For those who have not used PowerPoint previously, as you look at the modules in the curriculum, each page shows both the PowerPoint Slide View (top half of the page) and the Notes Page view (bottom half of the page). Speakers' notes for slides are provided in the Notes Page view of PowerPoint. Information provided in the Notes Page view includes: how to facilitate discussion of the data/information reviewed in the slide; how to incorporate the exercises to support participant learning; and guidelines for how to use the tools and handouts during the training.

If you have not used the Notes Page view in PowerPoint before, it can be accessed by selecting the tab called "View" across the top of your computer screen and then selecting the "Notes Page" option. This means that you can access the speakers' notes during your presentation or while you are preparing for a presentation by changing the view on your screen in PowerPoint.

FUTURES strongly recommends partnering with local domestic violence advocates at local shelters and advocacy programs and having them participate in the training.

There are several factors that will influence the length of your training when you use these slides. Factors include:

- If you adjust the time allowed for interactive activities
- How much time you allow for questions and answers
- The amount of local/regional data and information that you add to your presentation

Intended audience:

This curriculum was designed for home visitors, perinatal case managers, community outreach workers, program managers and agencies that sponsor home visitation programs.

Time needed for training modules:

- If all of the training modules are used, this is an all-day training.
- Consider working with another trainer as a team. Ideally this team would include a domestic violence advocate and a home visitor.
- The curriculum is designed to be flexible. You can do it in one long day or two half days.
- Each module has its own learning objectives. The modules vary in length depending on the topic. Modules include discussion questions and/or activities which will influence the length of the training depending on how much time is allowed for these interactive components. While estimated times are provided for discussions and activities, these times could be extended so that the training event is more than one day in length.

! **Trainer's Tip:** There are many variables that influence the length of the training including the familiarity of the trainer with the material, the size of the audience, and the time allowed for discussion and activities. Consider doing a practice training with co-workers to become familiar with the content and how to conduct the activities in this curriculum. We strongly recommend that you keep the interactive activity in place for optimal adult learning.

Materials needed to conduct training:

(Many of these resources may be downloaded at www.FuturesWithoutViolence.org or ordered from our online catalog for a small shipping and handling fee.)

- Trainer's Curriculum and PowerPoint slides
- "Healthy Moms, Happy Babies" Safety Cards (see Appendix F; available at www.FuturesWithoutViolence.org)
- Did You Know Your Relationship Affects Your Health? Safety Cards (see Appendix E; available at www. FuturesWithoutViolence.org)
- PowerPoint set-up: laptop with DVD player or laptop and external DVD player, LCD projector, screen to project image onto, power cords, and extension cords if needed
- External speakers for your computer (this is very important to have so that your audience can hear the content of the video clips)
- Flip-chart with stand and markers
- Post-it notes
- Masking tape to tape completed flip-charts around the room
- Copies of handouts including the Pre- and Post-training Surveys and PowerPoint slides (select the option for "handouts" and "slides per page: 6" as the options under "print what" when printing your PowerPoint handouts)
- All participants should have a pen or pencil and a few sheets of note paper

Technical Skills for Trainers:

If trainers are not already comfortable using PowerPoint, trainers will need to become familiar and comfortable with this in order to provide training. A copy of the PowerPoint presentation can be downloaded at www.FuturesWithoutViolence.org. It is always important to be prepared for possible equipment issues such as getting your computer to connect to a LCD projector, so test the equipment ahead of time. Also, consider having a back-up projector and/or an extra bulb for the projector available during the training.

Trainer's Tip: Review the notes before the training and add tabs or markers for information in the notes that you want to highlight during the training.

How This Trainer's Curriculum is Organized:

Each training module comprises a separate section in this guide which includes:

- Estimated time
- Learning objectives
- Training outline (description of each slide)
- Overview
- Instructions for exercises and activities
- References for studies (in alphabetical order by author's last name by module)
- Resources

Important notes for Trainers:

- Due to the high prevalence of domestic violence and reproductive coercion among women in the general population, many participants may have had direct or indirect experiences with abuse.
- This type of training can trigger painful memories and feelings for participants. Talking about domestic violence, reproductive coercion, and the effects of violence on children are sensitive topics that can be emotional regardless of whether a person has had any direct experiences with abuse.
- Invite domestic violence advocates from your local/regional domestic violence program/shelter to participate in the training. They can provide the latest information on resources, contact information, and invaluable insights into the topics being discussed. Including domestic violence advocates in your training can help to build partnerships between home visitors and local domestic violence service providers.
- It is also advisable, whenever possible, to have a domestic violence advocate available during this type of training to talk to any participants who need additional support. If this is not possible, have the number of a local/regional DV program available during the training.
- Remember to be watchful of participants' reactions to the content of this training. Check-in during breaks with any participant that you think may be having difficulties during the training. Give extra breaks as needed, consider turning the lights down if someone is struggling with emotions, give participants an opportunity to debrief, and incorporate breathing and stretching exercises to reduce stress.

Training Site:

- Visit the location for the training ahead of time to determine equipment needs and considerations such as where the projector and laptop will be located, tables/carts for the projector and laptop, if extension cords are needed and what type, where the screen will go, etc.
- Whenever possible, round-tables are recommended versus traditional classroom seating to facilitate group work and discussion.
- Assess parking options, places to eat if lunch is not provided, and any information that you need to share with participants prior to the training.
- Provide refreshments if possible.

!

Trainer's Tip: To find more information about a study that has been referenced in a slide, go to www.ncbi.nlm.nih.gov/pubmed/ or use a search engine for the term "pub med". Once you are in Pub Med, you can enter the author's name and a word or two from the title of the publication to obtain a listing of publications for that author. Once you have identified the publication you are looking for, you can click on that title to access and print an abstract for that article at no cost. If you want to purchase the article, that information is often provided. Journal publications can also be accessed and copied at medical and university libraries.

LEARNING OBJECTIVES

As a result of this training, home visitors will better be able to:

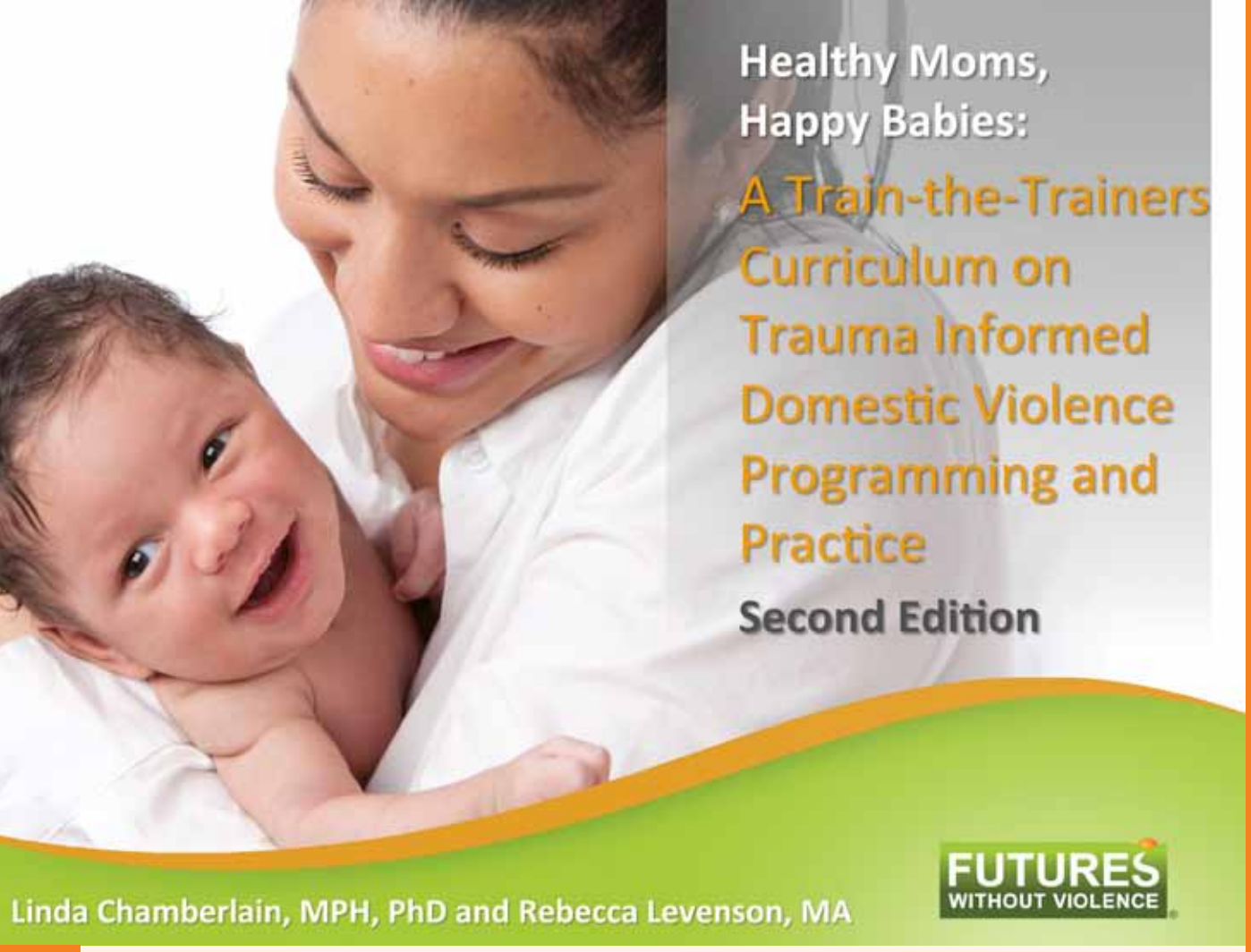
1. Describe trauma-informed programming.
2. Name two common reactions when caring for survivors of trauma.
3. Name two strategies for promoting self-care related to trauma-informed workplace practice.
4. Describe the prevalence of domestic violence.
5. List two ways domestic violence affects perinatal health.
6. Give two examples of reproductive coercion.
7. Describe a tool developed to educate clients about reproductive coercion.
8. Identify two barriers to home visitors doing domestic violence assessment with clients.
9. Describe why universal education using the Healthy Moms, Happy Babies (HMHB) safety card is important for helping clients experiencing domestic violence.
10. Describe why the "Relationship Assessment Tool" is a good screening tool for domestic violence.
11. List action steps in a safety plan that a client can take if she feels unsafe.
12. Explain how developing a Memorandum of Understanding (MOU) with your domestic violence agency can enhance home visitation services.

Please note that each training module includes module specific learning objectives. These objectives are listed at the beginning of each module.

Sample Agenda for One-Day Training Using All Modules

8:30–8:45 am	Registration and Pre-Test
8:45–9:00 am	Welcome and Background
9:00–10:30 am	What About Me? Moving Toward a Trauma-Informed Understanding of How Our Work Can Affect Us
10:30–10:45 am	BREAK
10:45–12:15 pm	Overview of Domestic Violence, Perinatal Health, and Reproductive Coercion: Definitions and Dynamics
12:15–1:15 pm	LUNCH
1:15–2:45 pm	Assessment and Safety Planning for Domestic Violence in Home Visitation
2:45–3:00 pm	BREAK
3:00–4:00 pm	Assessment and Safety Planning for Domestic Violence in Home Visitation continued
4:00–4:15 pm	Closing and Post-Test

Introduction and Workshop Guidelines



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Training Outline

- Pre-training survey (see Appendix A)
- Workshop guidelines
- Review the importance of addressing domestic violence in home visitation programs
- Next steps to get started

Overview

The purpose of this curriculum is to help the learner understand how screening for Domestic Violence (DV) can make a difference in the lives of women and children. The curriculum makes the case for home visitors—showing how DV is connected to many other home visitation program outcome goals, and most importantly, demonstrates how talking with home visitors makes women safer and more likely to seek domestic violence advocacy services.

Workshop Guidelines

- Because domestic and sexual violence (DSV) are so prevalent, assume that there are survivors among us.
- Be aware of your reactions and take care of yourself first.
- Respect confidentiality.
- Please turn off your phones, laptops, tablets, etc.

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2

Notes to Trainer: It is very helpful to have a domestic and/or sexual violence advocate present or on call when you are doing a training on domestic and sexual violence (DSV). This type of training can trigger painful memories while also creating the opportunity for survivors to process their feelings and experiences.

Discuss confidentiality, specifically state "what we say here, stays here." Information that participants may choose to disclose in the workshop should NOT be shared outside of the room.

Encourage participants to do what they need to feel safe and comfortable throughout the training such as leaving the room and taking unscheduled breaks. They may also approach one of the trainers at breaks or lunch to talk about issues. As a trainer, you should anticipate that survivors will come forward and want to talk to you or an advocate for support.

Remain aware of anyone who may be reacting to or be affected by the content of the training. Consider giving extra breaks after particularly sensitive material, or when you observe that someone is having a difficult time. Connect with that person during the break to check-in and ask if he or she would like to talk with someone and determine how follow-up can occur.

Estimated Activity Time: 5 minutes

Notes to Trainer: Hand-out the pre-training survey for participants to complete and let them know that they will be asked to do a post-training survey. Allow approximately five minutes for participants to complete the survey. Tell participants that they do not need to put their names on the surveys and that their responses are confidential.

National Health Resource Center on Domestic Violence

Provides free technical assistance and tools including:

- Clinical guidelines
- Documentation tools
- Posters
- Pregnancy wheels
- Safety cards
- State reporting laws
- Training curricula
- Online toolkit at www.healthcaresaboutIPV.org

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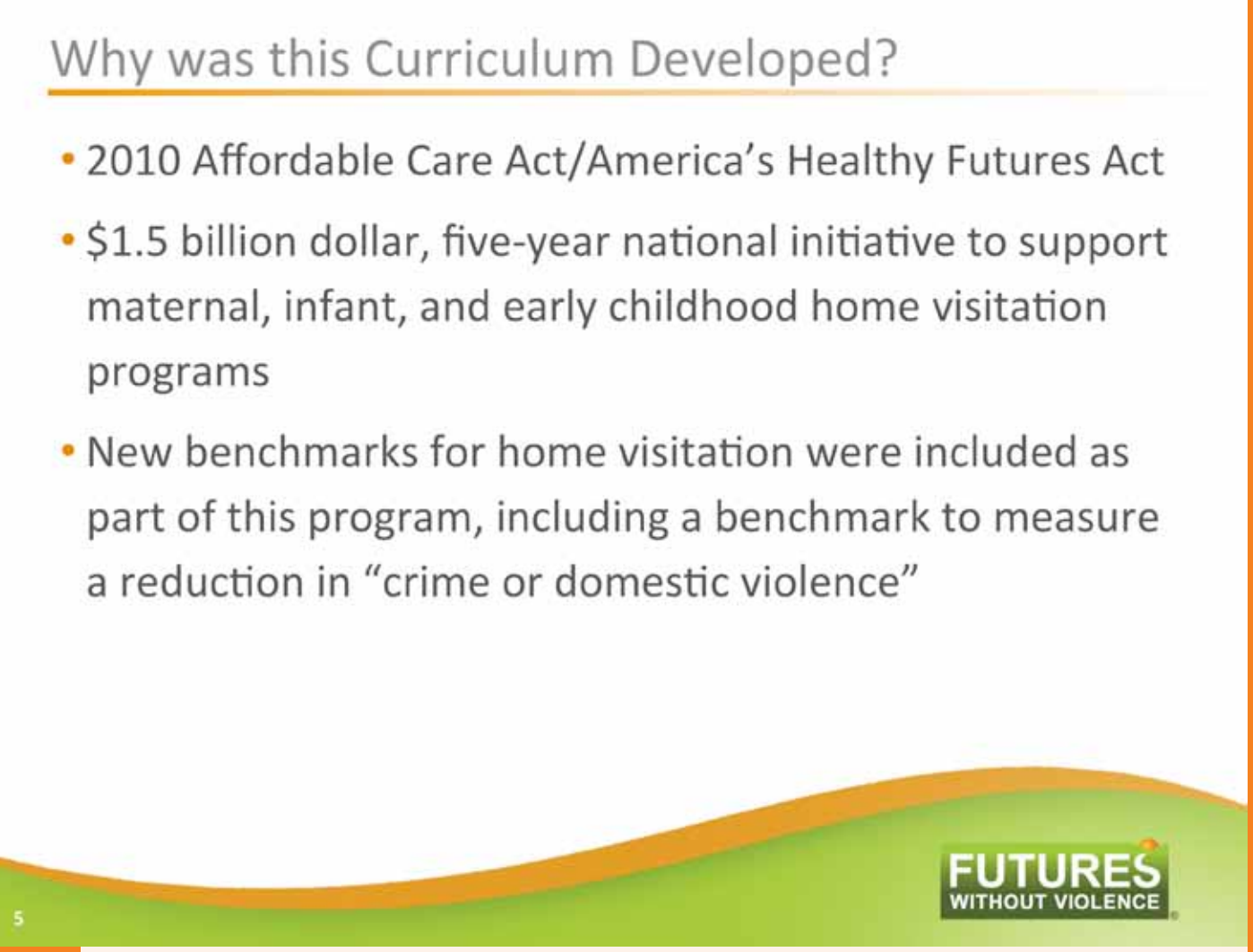
Notes to Trainer: For more information, please visit the National Health Resource Center on Domestic Violence website, www.futureswithoutviolence.org/health/national-health-resource-center-on-domestic-violence



Notes to Trainer: The Affordable Care Act was passed in 2010 and included provisions to support America's Healthy Futures Act, a 5-year national initiative to support maternal infant and early childhood home visitation programs. The legislation also included new benchmark requirements for states. One benchmark requires home visitation programs to measure a reduction in "crime or domestic violence". Futures Without Violence has been working with home visitation programs and providing domestic violence and child abuse training and education for more than a decade in an effort to transform how home visitors address and support families facing abuse through our *Healthy Moms, Happy Babies* curriculum.

Curriculum Focus and Limitations

- **Curriculum Goal:** Teach home visitors how to screen mothers/women for domestic violence (DV) using the evidence-based Relationship Assessment Tool, provide safety planning, and make referrals that meet the Federal benchmark requirements.
- **Curriculum Limitations:** Men can also be victims of DV—and teens can be victims of other family violence that put them at risk. We care about these issues. However, assessment for these issues is not included in the benchmarks, so our data, tools and focus are narrowed to mothers and female caregivers.

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Adult Learning Principles

Adults are:

- Internally motivated and self-directed
- Bring life experiences and knowledge to learning experiences
- Goal oriented
- Relevancy oriented
- Practical
- Like to be respected

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7

Introduction

Notes to Trainer: We want to start where adult learners are and thus use an asset-based approach, building on their already-existing knowledge and expertise. This eases acceptability of training and integration of learning.

Notes to Trainer: This is why adult learning theory and curricula are **SO** important. Please read slide aloud.

Why did you become a Home Visitor?

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Estimated Activity Time: 5 minutes

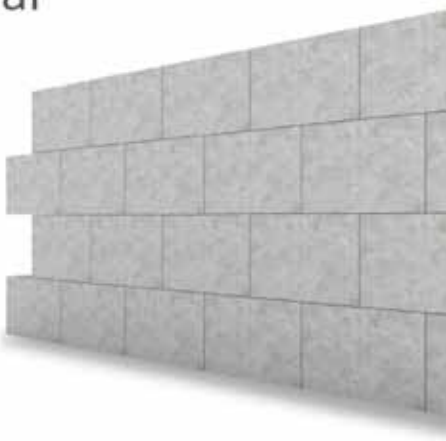
Notes to Trainer: We ask this question because many home visitors experience work fatigue. Thinking about and responding to this question helps participants connect back to their positive memories surrounding the work they do. Follow the directions below.

1) Ask participants to discuss this question for five minutes. Break participants up into pairs of two, if feasible. Each person should take 1-2 minutes to tell their partner their reasons why (no interruptions).
2) Ask participants if anyone is willing to share their answers.

Breaking Down Institutional Barriers

Why has it been difficult for many states to meet their goals with the DV benchmark?

- Persistent systematic and personal barriers to screening
- Child protection services (CPS) reporting fears
- Staff's own personal and/or vicarious trauma
- Limitations of screening tools in this context



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10

Notes to Trainer: We learned that we needed to take into account why staff haven't been able to comply with the benchmark.

Optional large group discussion: What might get in your way when addressing intimate partner violence?

- Ask participants to identify their personal barriers in addressing intimate partner violence.
- Ask participants to think about structural or process barriers that may exist in their service sites.

Wellness Lens

- It's about building resiliency skills and resilient organizations
- Paradigm shift from what is wrong to where we want to go

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11

Notes to Trainer: This curriculum was created through a wellness lens. We want to move beyond bad things associated with DV to a larger framework of resiliency, healing, and strength.

Addressing the Barriers

Simplify process of screening for and providing universal education about DV for home visitors.

- Connect DV to self, health, and parenting
- Safety card intervention
- Strategies for warm referral & support
- Video case studies

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12

Notes to Trainer: The safety-card based assessment that will be presented today is a unique new approach to addressing DV, reproductive and sexual coercion in home visitation settings. Home visitors are in the unique position to help their clients make the connection between experiencing violence and health risks, offer harm reduction strategies if clients disclose reproductive coercion and/or DV, and make warm referrals to local DV programs and/or the National Domestic Violence Hotline.

Definition of Cultural Humility

"...not a discreet endpoint, but a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with clients, communities, colleagues, and with themselves."

- Leland Brown, 1994

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13

Introduction

Notes to Trainer: As we mentioned at the outset, this is the second edition. It reflects what we've learned over the past three years and the wisdom of the home visitors who have applied this work in the field. Just as we continue to engage in an ongoing process of asking ourselves the hard questions, "What have we learned? How can we make it better? What resonates with clients? How do we continue to figure out ways to best support HVs in their work around DV?" We hope that the home visitors are doing this as well. There is no end point to learning; it is a continually evolving process.

In fact, the definition of cultural humility is that it is not a discreet endpoint, but a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with clients, communities, colleagues, and themselves. It asks one to inquire and seek to understand rather than judge and assume.

Why is this important?

The humility concept pushes people and home visitors to continue to grow. To this point, when we look to the community (home visitors) and client as expert teacher, it flips the power dynamic in a way that can be profound for the clients as well as you.

Building Alliances: Purpose of Warm Referrals

- **WHO** are the other programs and partners serving these same families?
- How do we build stronger training alliances, warm referrals and common understanding?
- How do we build a common language and conversation between partners as we serve families?

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14

Notes to Trainer: How do we move supporting referrals out of organizational silos on the issue of DV? How do we help mental health and substance abuse providers recognize the connection to DV in our referrals? How do we better create statewide strategies to address the whole family and their problems through a DV lens?

A key step in developing a supported referral is to connect with existing support services for DV in the community. Getting to know your local DV program staff will help ensure that each referral feels genuine and supportive to your clients—bringing other allied support programs like WIC or substance abuse or mental health referrals to HMHB will help all programs be on the same page. Making this connection can be mutually beneficial. Team-training with domestic violence advocates from local programs acknowledges their expertise and provides an opportunity to build working partnerships. DV advocates are also an excellent resource for training and advocacy.

Lessons Learned: Granular Level

True or False

- Does it matter how DV screening tools are introduced?
- Does your body language and/or the way you frame questions affect the outcomes of an interaction?
- Does the kind of supervision you receive affect your ability to do this work?

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Notes to Trainer: Do we understand DV screening in the context of being a strategy for self-care? The way we approach the tools we use might be more about our feelings than about the client's feelings. When we understand how our lens may be impacting our behavior, we can begin the real work with families. A big picture perspective in terms of goals for home visitation programs has the potential to impact staff retention, client retention and new client enrollment.

What happens when screening allows staff to miss the point?

- How many of you have ever been screened for domestic violence?

Think about EXACTLY what happened.

- Was it a good experience?
- Was it a bad one?

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Estimated Activity Time: 2 minutes

Notes to Trainer: Ask participants to answer questions by a show of hands. Ask audience what made an experience good? Bad? Ask for a few examples of both—be prepared to offer examples if there are none provided by the audience.

- Example of a bad screening, when you are asked in front of a partner. This set up makes it both potentially unsafe but also sends a message that the provider is expecting a 'no' answer.
- Why doesn't the checklist approach to screening work? Meaning, if we are just checking boxes we are missing the larger point.

DO NO HARM

- What is *your* goal for DV screening?
  - Data collection?
  - Education?
  - Support?
- How do *you* define success?
- How does *your* program define success?

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17

Notes to Trainer: Ask the audience to reflect on their answer to the questions posed on the slide and what their program's answer might look like. The goal is to ask them to dig deep and consider what the answer is for them and their program.

Notes to Trainer: How do we get to a place where every time we talk to a client about DV, it's a conversation not a checklist? If you've learned this another way, then this is about undoing that. It takes practice and decisive action to change what you do.

Module 1: What About Me?: Moving Toward a Trauma-Informed Understanding of How Our Work Can Affect Us

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Module 1

What About Me?: Moving Toward a Trauma-Informed Understanding of How Our Work Can Affect Us

Estimated Module Time: 90 minutes

(Depending on the amount of discussion time and activities)

Training Outline

- Learning objectives
- Secondary traumatic stress
- Strategies for home visitors and program managers
- Self-Care and Relationship Checklist (see Appendix B)
- Organizational self-assessment tool

Overview

Working with clients who experience trauma can affect the caregiver/service provider, creating secondary traumatic stress. This module reviews self-care strategies for caregivers and policies that managers can implement to support their staff.

The subsequent slides can be used as a large group brainstorming session to ask participants what they do to enhance their safety during home visits, especially when they suspect or know that domestic violence is occurring in a household.

Learning Objectives

After this training, participants will be better able to:

1. Describe trauma-informed programming.
2. Name two common reactions when caring for survivors of trauma.
3. Name two strategies for promoting self-care related to trauma-informed workplace practice.

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Notes to Trainer: Read the learning objectives aloud.

Being Trauma-Informed Starts With Us

- Trauma is prevalent
- Assume that there are survivors among us
- Be aware of your reactions and take care of yourself first
- Respect confidentiality

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21

Notes to Trainer: It is very helpful to have a domestic violence advocate present or on call when you are doing a training on domestic violence. This type of training can trigger painful memories while also creating the opportunity for survivors to process their feelings and experiences. Let participants know to take a break if they need it, to remember to breathe, and to let you know if they need anything.

Encourage participants to do what they need to feel safe and comfortable throughout the training such as leaving the room and taking unscheduled breaks. They may also approach one of the trainers at breaks or lunch to talk about issues. As a trainer, you should anticipate that survivors will come forward and want to talk to you, or an advocate for support .

Remain aware of anyone who may be reacting to or be affected by the content of the training. Consider giving extra breaks after particularly sensitive material, or when you observe that someone is having a difficult time. Connect with that person during the break to check-in and ask if he or she would like to talk with someone and then determine how a follow-up can occur.

"To put the world in order, we must first put the nation in order, to put the nation in order; we must first put the family in order; to put the family in order, we must first cultivate our personal life; we must first set our hearts right."

- Confucius

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22

Notes to Trainer: The image at the top of the slide is from an artist called Cristo. The art installation, called *The Running Fence,* is composed of white fabric run across many miles in Marin county, CA. The 'fence' went through ranch and farm land and through other individual properties—making this happen took a huge amount of work. As one might imagine, many owners were skeptical about participating. The beauty of this art is that it required individual work—thus changing the individual in order to make the whole.

This quotation from Confucius provides the rationale for this module. In order to be able to do good work with parents and children, we must first "set our hearts right".

What is Trauma?

- An experience that is overwhelming for that person.
- Trauma might look different for you or me, but we've all experienced it.

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23

Notes to Trainer: Whether its family violence or something else the benefit of coming from an universal framework is that it's not an us versus them or you versus me, but rather an all of us issue. It doesn't leave anyone out. It doesn't shame anyone.

Historical, Cultural and Intergenerational

- **Cultural trauma**: an attack on the fabric of a society, affecting the essence of the community and its members
- **Historical trauma**: cumulative exposure to or of traumatic events that affect an individual and continue to affect subsequent generations
- **Intergenerational trauma**: when trauma is not resolved, subsequently internalized, and passed from one generation to the next.

(D.S. BigFoot, 2007 ©)

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24

Notes to Trainer: What is our goal here? Our goal is to recognize that trauma goes beyond the car crash or witnessing violence. Trauma can be historical, cultural and intergenerational, too.

Optional exercise: Ask participants to give examples of cultural (example: 9/11), historical (Jews and the holocaust, American Indians and colonization, African Americans and slavery, etc.), and intergenerational trauma (cycle of abuse repeated). Ideally as we become more trauma informed, we have an opportunity to examine our personal beliefs and assumptions about how other kinds of trauma may affect our clients:

- A process of connecting our histories with our current selves
- An awareness of how values, biases, cultural background, regional perspectives, personal history, and beliefs impact our work with children and parents
- The process of opening up space for emotional and intellectual exploration

www.isu.edu/irh/projects/ysp/downloads/CulturalIssuesinHistoricalTrauma.pdf

Close your eyes. Think of a time when you felt helpless. What was going on in your body at that time?

- Body temp changes
- Smells heightened
- Feel unpleasant sensations (nauseated, dizzy, lightheaded, not enough air in the room, "I got to get out of here")

Example: Car Accident

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25

Notes to Trainer: Ask the audience to think about a time when they felt helpless—not hugely helpless, something smaller but still with impact. They locked their keys in a car during a snowstorm. They lost their child for 5 minutes in a grocery store. Their cell phone died at the worst possible moment and they didn't have a charger.

Ask participants to take themselves back to that moment with their eyes closed. How did they feel? What did they smell? How fast were their hearts beating? What else physiologically went on with them at that time? Then ask them to open their eyes. Ask participants, beyond this list were there other things that they noticed going on within themselves? For some of them, they may have disassociated, climbed out of their bodies and watched from above. There is a physiological response that occurs. It happens to all of us.

Grounding Exercise To Promote Resiliency

Resiliency Skills – bring yourself back into your body.

- Stand up and put your back against the wall—this helps you stay connected to your body
- Wrap your arms around you and give your self a hug, rub your arms
- Rub hands under cold water in the bathroom—this reconnects you with your surroundings and external sensations

(Levine & Mate, 2010; Levine 1997)

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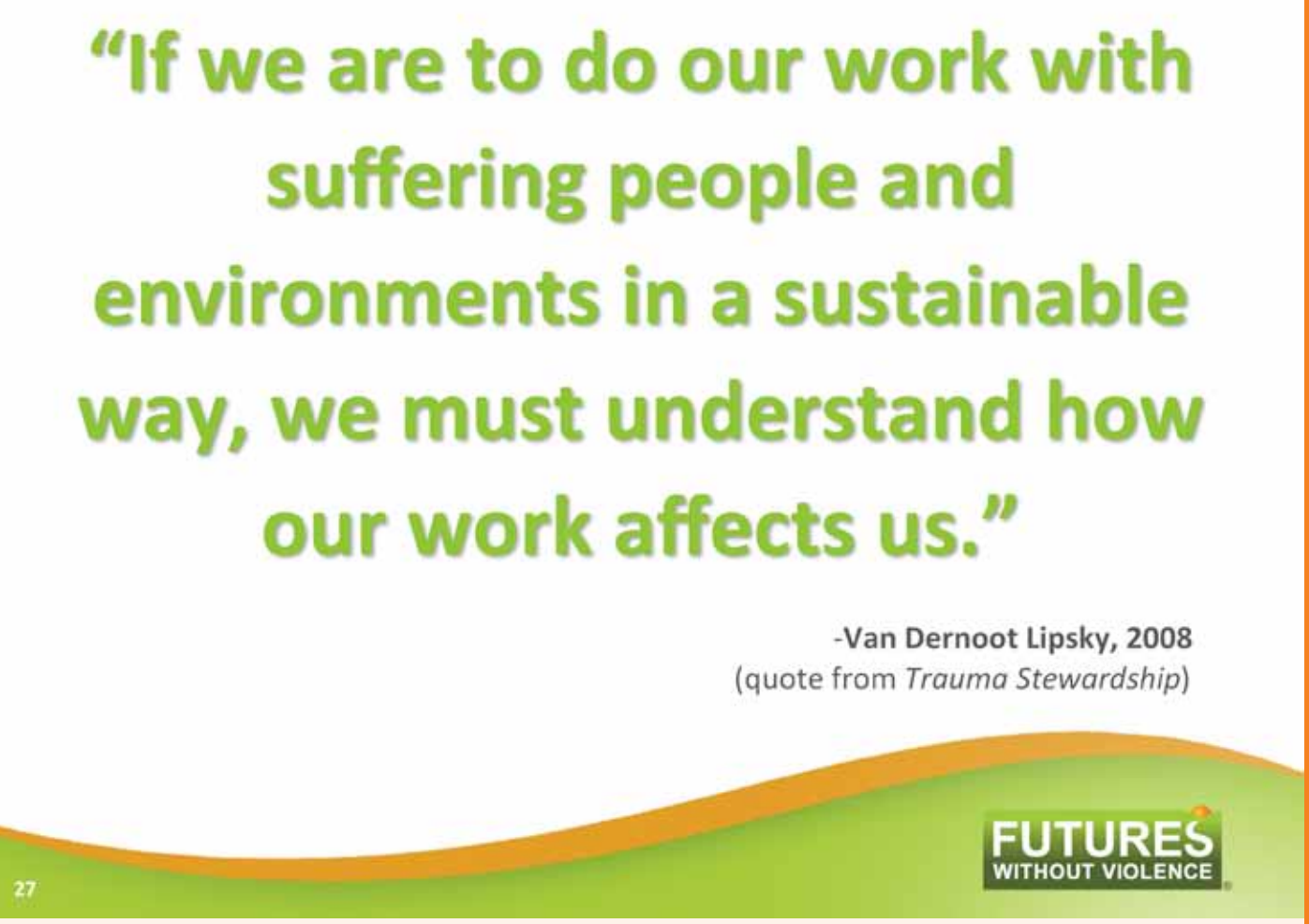
26

Notes to Trainer: Given that we just took you to a time when you were upset, some of those physical reactions are being repeated inside of you. This exercise is about showing you how you can help yourself and a tool that you can teach to your clients as well. If participants can't do the exercise, have them hold themselves tight and rub their arms.

Both of these exercises, back against the wall or rubbing arms and hugging self, can help stop you from disassociating.

In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness by Peter Levine and Gabor Mate, 2010
Waking the Tiger: Healing Trauma - The Innate Capacity to Transform Overwhelming Experiences by Peter A. Levine 1997



Estimated Activity Time: 2 minutes

Notes to Trainer: Ask someone in the audience to read the quote on the slide. Ask the audience if they think this is important and why.

What is Vicarious Trauma?

Vicarious trauma is a change in one's thinking [world view] due to exposure to other people's traumatic stories.

(Dr. David Berceli, 2005)

28

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Notes to Trainer: Read the definition aloud.

Vicarious traumatization (VT) is a self-transformation of a **trauma** worker or helper that results from empathic engagement with **traumatized** clients and their reports of traumatic experiences. Its hallmark is disrupted spirituality, or a disruption in the **trauma** workers' perceived **meaning** and hope.

Secondary traumatic stress, also referred to as vicarious trauma, burnout, and compassion fatigue, describes how caring for trauma survivors can have a negative impact on service home visitors.

This is not a judgment but a reality of the job.

Vicarious Resilience

There can also be strengths that come from working with clients who have experienced trauma

- Witnessing others overcome adversity
- Recognizing people's capacity to heal
- Reaffirming the value of the work you do
- Gift of hope

Vicarious resilience can buffer the effects of stress associated with vicarious trauma, strengthen our motivation, and give us new, meaningful perspectives.

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Personal Exposures to Violence and Secondary Traumatic Stress are Connected

- Lifetime exposure to violence is common
- Working with clients who are experiencing or have experienced violence can trigger painful memories and trauma
- Personal history of exposure to violence increases risk for experiencing secondary traumatic stress

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What are Common Reactions to Caring for Survivors of Trauma?

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31

Notes to Trainer: Use an easel to record the audience's comments and fill in the missing thinking with a review of the next slide while only focusing on **KEY** issues that were missed.

Common Reactions to Caring for Survivors of Trauma

- Fear
- Helplessness
- Sleep disruptions
- Depressive symptoms
- Feeling ineffective with clients
- Recurrent thoughts of threatening situations
- Reacting negatively to clients
- Thinking of quitting clinical [contact with clients] work
- Chronic suspicion of others

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Examples of Work-Related Vicarious Trauma

- Someone you've supervised for years has developed a new habit of checking in with you before making any decisions, and questioning if his/her actions have any value for clients
- Outreach worker has nightmares about traumatic experiences of her clients

("What About You?" 2008)

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33

Notes to Trainer: Ask participants if their colleagues may have issues like this but not attribute them to vicarious trauma.

What About You?: A Workbook for Those Who Work with Others, Katherine T. Volk, Kathleen Guarino, Megan Edson Grandin, and Rose Clervil, © 2008: The National Center on Family Homelessness.
Available at: www.familyhomelessness.org/media/94.pdf

How many of you actively take extra care of yourselves when it comes to this work?

On a scale of 1 (Not at all) to 5 (Routinely)

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Notes to Trainer: Funny image of two little girls who were weaned off their binkies and found the stash when their mommy wasn't looking. Why have one when three is better?

What Works for You?

This is what works for me, don't judge.

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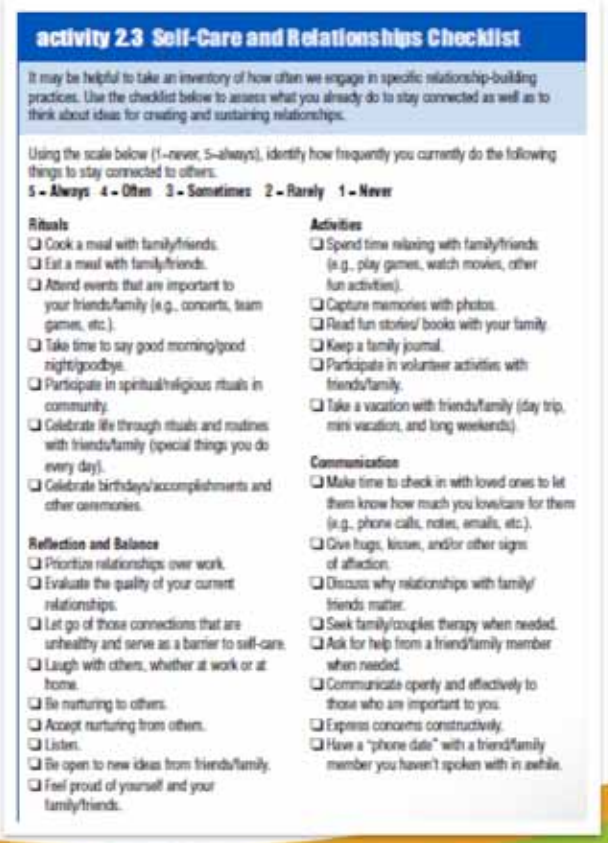
Estimated Activity Time: 5 minutes

Notes to Trainer: Ask participants, how is vicarious trauma manifested? Some answers that may be brought up include:

- Comfort Food (For example: French Fries)
- Boundary Violation and Transference
- Chronic lateness
- Taking excessive responsibility for the client
- Use of Alcohol and Drugs
- Physical symptoms
- Inability to relax or enjoy pleasurable activities
- Anger
- Reacting angrily to clients/staff/colleagues
- Feelings of guilt
- Detachment
- Avoiding clients

Self-Care and Relationship Checklist



activity 2.3 Self-Care and Relationships Checklist

It may be helpful to take an inventory of how often we engage in specific relationship-building practices. Use the checklist below to assess what you already do to stay connected as well as to think about ideas for creating and sustaining relationships.

Using the scale below (1–never, 5–always), identify how frequently you currently do the following things to stay connected to others.

5 – Always 4 – Often 3 – Sometimes 2 – Rarely 1 – Never

Rituals
- ❑ Cook a meal with family/friends.
- ❑ Eat a meal with family/friends.
- ❑ Attend events that are important to your friends/family (e.g., concerts, team games, etc.).
- ❑ Take time to say good morning/good night/goodbye.
- ❑ Participate in spiritual/religious rituals in community.
- ❑ Celebrate life through rituals and routines with friends/family (special things you do every day).
- ❑ Celebrate birthdays/accomplishments and other ceremonies.

Reflection and Balance
- ❑ Prioritize relationships over work.
- ❑ Evaluate the quality of your current relationships.
- ❑ Let go of those connections that are unhealthy and serve as a barrier to self-care.
- ❑ Laugh with others, whether at work or at home.
- ❑ Be nurturing to others.
- ❑ Accept nurturing from others.
- ❑ Listen.
- ❑ Be open to new ideas from friends/family.
- ❑ Feel proud of yourself and your family/friends.

Activities
- ❑ Spend time relaxing with family/friends (e.g., play games, watch movies, other fun activities).
- ❑ Capture memories with photos.
- ❑ Read fun stories/ books with your family.
- ❑ Keep a family journal.
- ❑ Participate in volunteer activities with friends/family.
- ❑ Take a vacation with friends/family (day trip, mini vacation, and long weekends).

Communication
- ❑ Make time to check in with loved ones to let them know how much you love/care for them (e.g., phone calls, notes, emails, etc.).
- ❑ Give hugs, kisses, and/or other signs of affection.
- ❑ Discuss why relationships with family/ friends matter.
- ❑ Seek family/couples therapy when needed.
- ❑ Ask for help from a friend/family member when needed.
- ❑ Communicate openly and effectively to those who are important to you.
- ❑ Express concerns constructively.
- ❑ Have a "phone date" with a friend/family member you haven't spoken with in awhile.

("What About You?," 2008)

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Notes to Trainer: Ask the participants to take out and review hand out. After asking them to do a quick review of the list ask if there are anyways they take care of themselves that are not on the list. This is a good example of a tool that you can bring back and do with colleagues.

What About You?: A Workbook for those Who Work with Others, Katherine T. Volk, Kathleen Guarino, Megan Edson Grandin, and Rose Clervil, Copyright 2008: The National Center on Family Homelessness.
Available at: www.familyhomelessness.org/media/94.pdf

Good Supervision is:

- Safe, non-judgmental, and supports staff growth and self awareness
- Provides positive regard and caring
- Is regular and reliable
- Uses a strength-based approach
- Provides space for reflection

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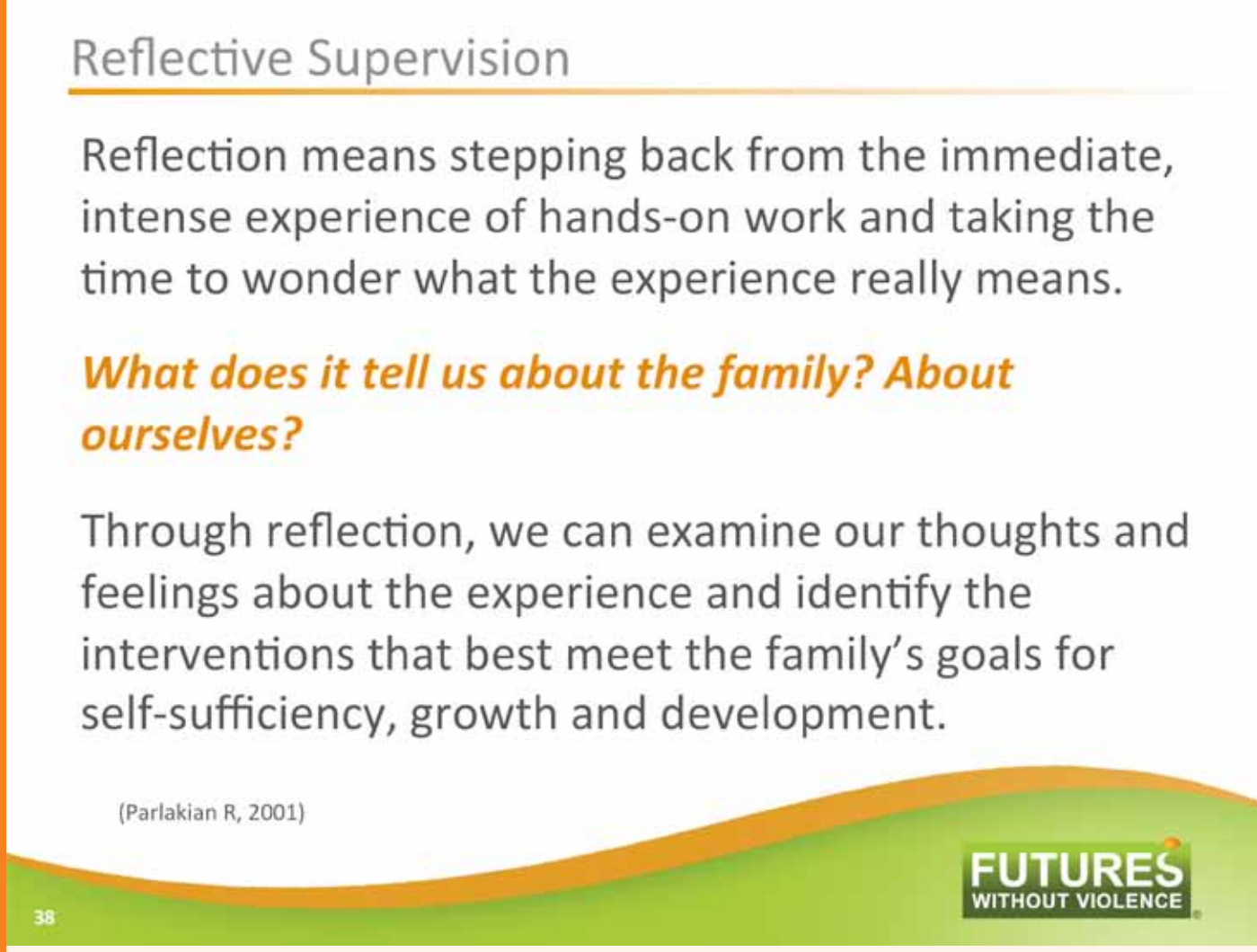
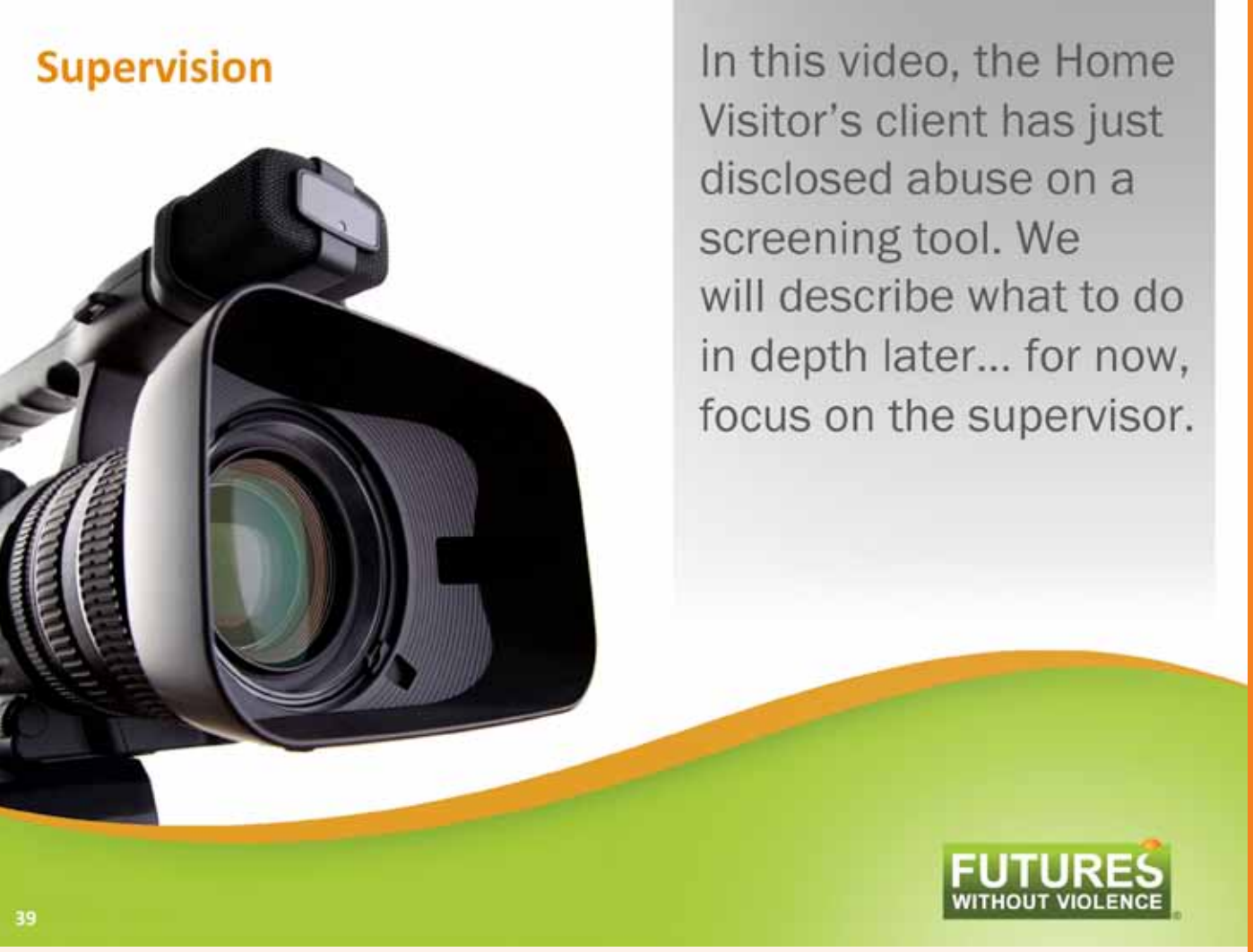
Note to Trainer: One way to support reflective practice in the workplace is to have reflective supervision.

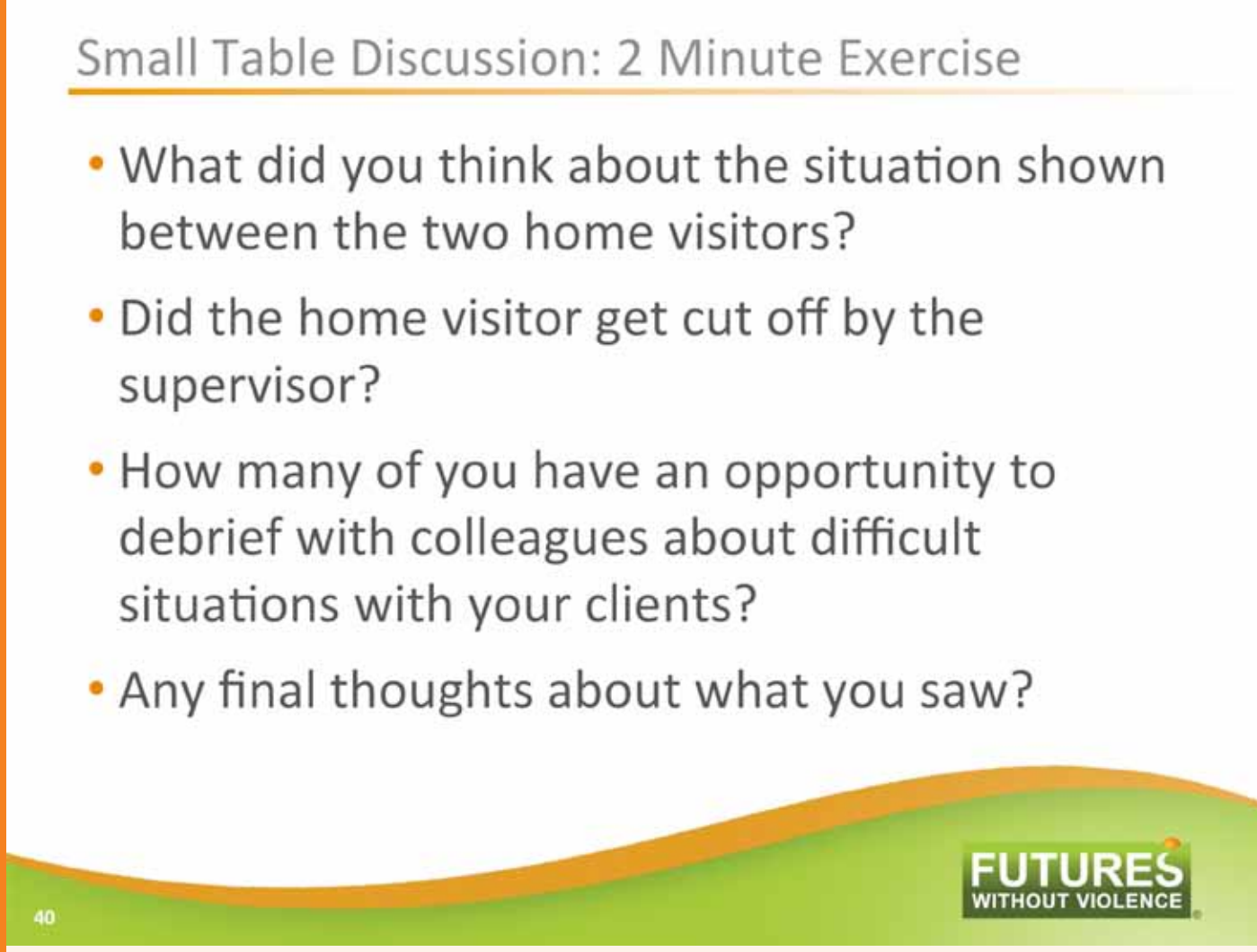


Notes to Trainer: For more information on reflective supervision: www.zerotothree.org/about-us/areas-of-expertise/reflective-practice-program-development/three-building-blocks-of-reflective-supervision.html

Excerpted from Parlakian, R. (2001). Look, listen, and learn: Reflective supervision and relationship-based work. Washington, D.C: ZERO TO THREE.



Estimated Activity Time: 4 minutes to watch video



Estimated Activity Time: 5 minutes

Notes to Trainer: Ask participants to discuss the following questions with their tables or in a small group. Give groups 3-4 minutes. Afterwards ask a couple of groups to share their thoughts.

1) What did you think about the situation shown between the two home visitors at the end of the video?
2) How many of you have an opportunity to debrief with colleagues about difficult situations with your clients?
3) What made this the opposite of reflective supervision?
4) Any final thoughts about what you saw?

Thoughts from Michigan Home Visitation

- In the same way home visitors are assessing clients—clients are assessing home visitors
- Clients don't need "fixing," they want coaching
- Good supervision includes highlighting this point—home visitors are coaches
- Coaching concept also takes the burden off the home visitor
- Rather than 'carrying' or 'fixing' the client it holds a value around the client helping themselves. This helps clients feel empowered

41

Note to Trainer: Ask participants what do they think about the thoughts shared from the Michigan home visitation program?

Low-Impact Debriefs: Preventing Re-traumatization

- There's a contagion factor to sharing gory details
- May see talking about trauma as normal part of work —become "desensitized" to it but research shows otherwise
  - Negative impact of cumulative exposure whether we are aware of it or not
- Two types of debriefing
  - Informal (ad hoc, talk to colleague etc.)
  - Formal (structured, scheduled) debriefing

(Mathieu F, 2008)

42

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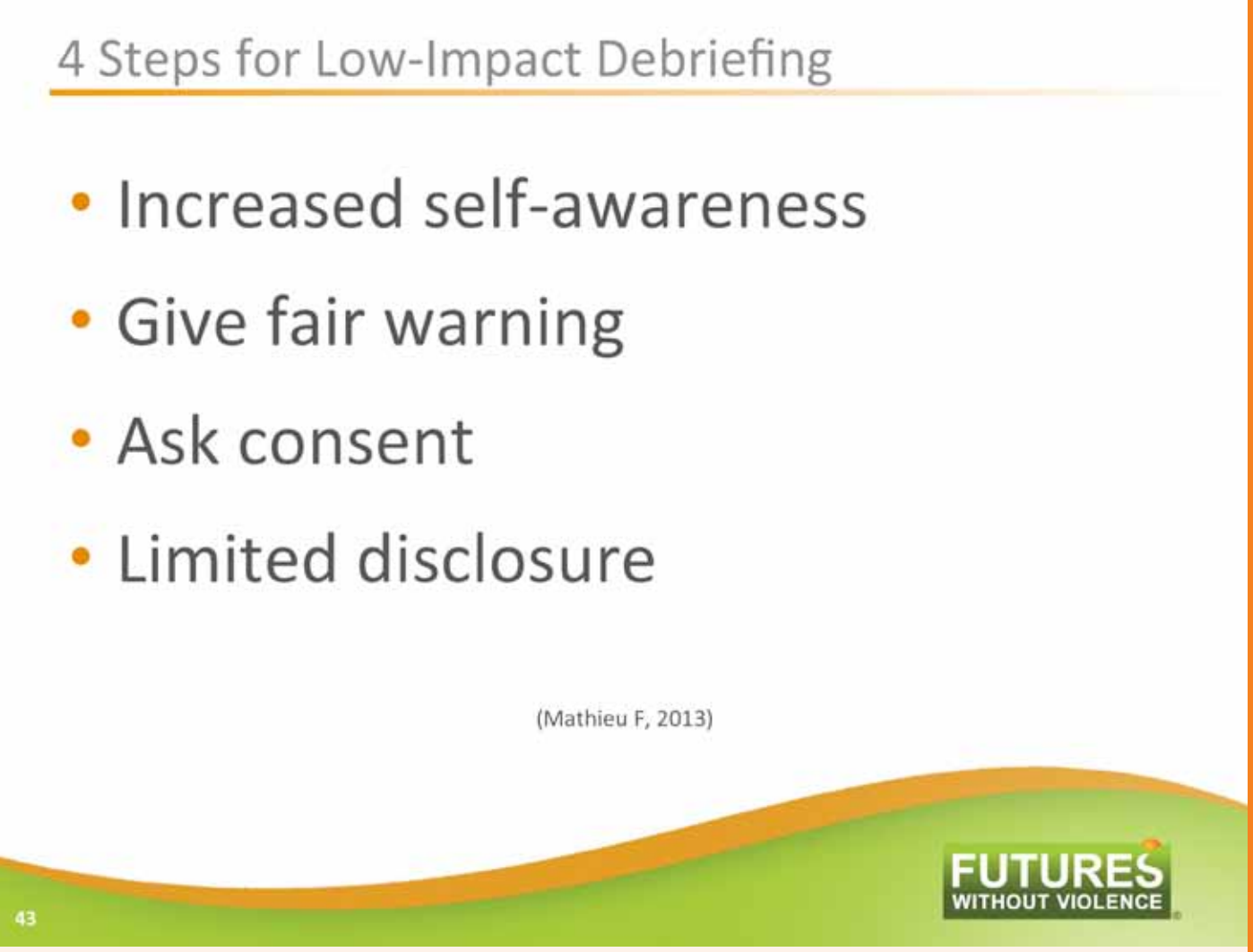
Notes to Trainer: Here is an example of how to do a trauma-informed debrief with your colleague. For more information, go to: www.compassionfatigue.org/pages/LowImpactDisclosure.pdf

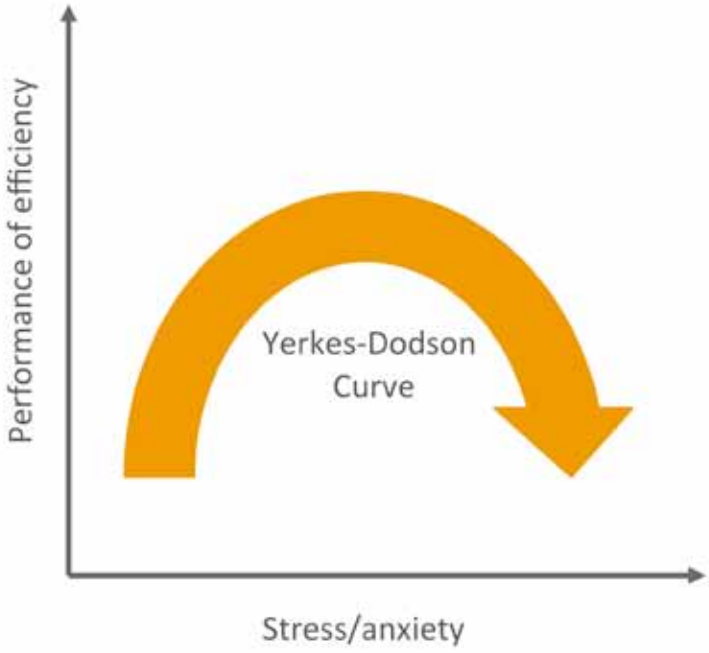


Notes to Trainer: The idea with low impact debriefing is that we are not dumping a massive amount of garbage on someone about our day or a client—we want to respect their boundaries and ask permission.

1) **Increased self awareness**—Become aware of the stories you tell and the level of detail. What details do I need to share?
2) **Give Fair Warning**—Think about what you would say first to someone if you were sharing bad news? "You better sit down. I need to tell you something…"
3) **Ask Consent**—I need to debrief with you. Is now a good time?
4) **Limited disclosure**—Start with the outer circle of your story and as you move in, decide how much of the graphic details you need to include. Check in with yourself-is this too much trauma information to share?

For more information, go to:
www.compassionfatigue.ca/wp-content/uploads/2008/10/Short-LID-article.pdf

Yerkes-Dodson Law



As stress increases, heart rate, blood pressure and muscle tension go up—this can initially enhance performance but past a certain level performance drops off dramatically.

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Notes to Trainer: This is what we are trying to prevent by addressing self-care and trauma first.

Stress Management Tool: Relaxation Response

Focusing on your breathing (mindful breathing) helps to calm your brain → Relaxation Response

- Creates state of deep rest/relaxation that is opposite of "fight, flight or freeze"
- Increases brain activity in areas associated with attention focus and decision-making
- Releases chemical messengers in brain that are calming and give sense of well-being

(Benson H, 2000)

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45

Notes to Trainer: When Dr. Herbert Benson introduced this simple, effective, mind/body approach to relieving stress twenty-five years ago, his book became an instant national bestseller. Since that time, millions of people have learned the secret—without high-priced lectures or prescription medicines. *The Relaxation Response* has become the classic reference recommended by most health care professionals and authorities to treat the harmful effects of stress.

Discovered by Dr. Benson and his colleagues in the laboratories of Harvard Medical School and its teaching hospitals, this revitalizing, therapeutic approach is now routinely recommended to treat patients suffering from heart conditions, high blood pressure, chronic pain, insomnia, and many other physical ailments. It requires only minutes to learn, and just ten to twenty minutes of practice twice a day.

For more information, go to: www.relaxationresponse.org.

Benson, Herbert . The Relaxation Response. New York: HarperTorch, 2000

4-Step Breakout Principle to Manage Stress and Enhance Problem-Solving

- Really focus on a challenging problem by giving it all of your attention
- Take a break from the problem and do a relaxing activity (walk, mindful breathing)
- "Breakout" comes with new insights about the problem when you relax (due to Relaxation Response)
- Return to work on problem with new insights

(Benson H, 2000)

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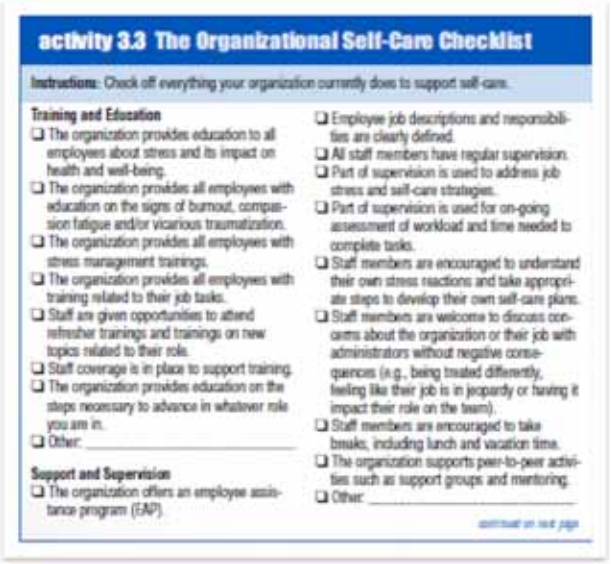
Notes to Trainer: Here is a description of how to come back to a problem with a 'breakout' or fresh insight.

Benson, Herbert. *The Relaxation Response.* New York: HarperTorch, 2000

Organizational Self-Care Check List



activity 3.3 The Organizational Self-Care Checklist

Instructions: Check off everything your organization currently does to support self-care.

Training and Education

- ❑ The organization provides education to all employees about stress and its impact on health and well-being.
- ❑ The organization provides all employees with education on the signs of burnout, compassion fatigue and/or vicarious traumatization.
- ❑ The organization provides all employees with stress management trainings.
- ❑ The organization provides all employees with training related to their job tasks.
- ❑ Staff are given opportunities to attend refresher trainings and trainings on new topics related to their role.
- ❑ Staff coverage is in place to support training.
- ❑ The organization provides education on the steps necessary to advance in whatever role you are in.
- ❑ Other: _____

Support and Supervision

- ❑ The organization offers an employee assistance program (EAP).
- ❑ Employee job descriptions and responsibilities are clearly defined.
- ❑ All staff members have regular supervision.
- ❑ Part of supervision is used to address job stress and self-care strategies.
- ❑ Part of supervision is used for on-going assessment of workload and time needed to complete tasks.
- ❑ Staff members are encouraged to understand their own stress reactions and take appropriate steps to develop their own self-care plans.
- ❑ Staff members are welcome to discuss concerns about the organization or their job with administrators without negative consequences (e.g., being treated differently, feeling like their job is in jeopardy or having it impact their role on the team).
- ❑ Staff members are encouraged to take breaks, including lunch and vacation time.
- ❑ The organization supports peer-to-peer activities such as support groups and mentoring.
- ❑ Other: _____

continued on next page

Like the self resiliency exercise, this organizational exercise helps supervisors and programs measure how well they are doing helping serve their clients.

("What About You?" 2008)

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Notes to Trainer: This instrument is designed to help agencies create trauma-informed, supportive work environments. It includes a checklist format for organizations to evaluate:

- Training and education
- Support and supervision
- Communication
- Employee control and input
- Work environment
- It also includes a self–assessment handout for employees.

What About You?: A Workbook for Those Who Work with Others, Katherine T. Volk, Kathleen Guarino, Megan Edson Grandin, and Rose Clervil, Copyright 2008: The National Center on Family Homelessness www.familyhomelessness.org/media/94.pdf (p.36-37)

Building Resiliency With Co-Workers

Name It and Write It Down:

- Three good things about a co-worker
- Three good things about your most recent client
- Three good things about yourself
- One positive thing you can do this week to take care of yourself

(Adapted from Linda Graham, 2013)

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Notes to Trainer: Tell participants they can use adjectives. If participants don't see clients, then ask them to write down three good things about their staff.

During debrief, ask the audience which question was the hardest to answer. Did any of participants write down three good things about their co-worker in the room? Ask them if they would be willing to share what they wrote about their colleague. Ask the colleague how it felt to hear that about themselves. Ask if this process would make it easier for them to come up with three good things about themselves.

Ask participants, why did we do this exercise? Explain that it is because we often forget to model for ourselves and in our work what is so important to do with clients. It's important to take time to care and value each other and ourselves. When we visit clients it's so important to remember that we may be the only person who compliments her—especially if she is experiencing domestic violence.

Lastly, this concept lends itself to a simple action that other programs have started doing. What if each week everyone wrote one good thing about each of their coworkers on sticky note and left it on their coworkers' desks? Ask them how many of them keep nice things supervisors, staff or clients wrote to them (ask for show of hands). It made them feel good or cheered them up on a bad day. What if we felt good every week rather than just occasionally?

Inspired and adapted from exercises in: *Bouncing Back: Rewiring Your Brain for Maximum Resilience and Well-Being* by Linda Graham (2013)

Simple Steps to Organizational Self Care

- Home visits completed by 3:30 pm on Friday every week
- No client appointments past 3:30 on Friday (phone call or in person)
- Staff check in that begins with ALL staff writing down three positive things about clients and colleagues
- Share a few positives before low-impact debrief of difficult cases
- Share a few more positives after the difficult cases
- It's all about how it ends!

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49

Notes to Trainer: Our recommendation is that every program have all home visits completed by 3:30 pm in the afternoon on Friday and they hold that time sacred for debriefing their caseloads and difficult cases and continuing quality improvement for their organizational self care practice.

The three positives could be cool things that made a difference in your week, that you heard about with co-workers or that you experienced with clients.

This kind of trauma informed organizational practice lends itself to reducing compassion fatigue and burn out and increasing staff retention. This kind of programming can increase productivity and can help a system save money by reducing the number of unplanned mental health days staff take.

Resource: Organizational and Self-Care Checklist, Appendix C.

Notes to Trainer: Ask the audience why the first two bullet points important? Point out the lower rates of screening compared to other states (many have as high as a 97% compliance rate) and compare that to the high rate of disclosure (most states hover around 4.6% positive disclosure rate). In other words, something is helping women feel safer and more comfortable sharing their experiences with IPV. (Feel free to read the next paragraph a loud).

In 2013-2014, Wisconsin state home visiting program screened 63.4% of female caregiver clients for DV within 60 days of enrolling in home visiting. We think that training and support for home visitors—on multiple levels and in a variety of ways—has an effect on program participants' willingness to disclose DV to them. Not only has WI offered regular 2 day HMHB's trainings (allowing for more time for practice and more time for conversation), but have also embedded the training in a trauma-informed professional development system that builds home visitor skills to become more attuned with the families they serve, offer opportunities for peer-to-peer support through communities of practice and facilitated reflective practice sessions, and promotes reflective supervision as best practice.

Promoting reflective practice in home visiting: The State Home Visiting Program has partnered with the Department of Health Services and the Wisconsin Alliance for Infant Mental Health to implement a Home Visiting Reflective Practice Project. The project includes three key components: training and coaching on reflective practice/reflective supervision; monthly consultation groups for the state funded home visiting programs with a reflective infant mental health consultant and one-on-one consultation for program supervisors.

Communities of Practice: The key objective of the CoPs is to systematically engage home visiting program staff in collaborative dialogue, reflection, and inquiry to further professional development and improve practice. Practitioners gain by increasing their critical thinking skills, building their professional networks, and developing solutions for shared challenges. Wisconsin uses MIECHV funds to support planning and facilitation of CoPs through the training staff at UW-M and their contracted TA providers.

Mindful Practices help people to slow down, become self-aware, and present in the moment. We start with you so you can help clients.

- Stand
- Lift arms toward the ceiling while taking deep breath in and then reach higher
- Exhale while you bring your arms down
- Repeat sequence four times

"Does anything feel different now?"

We will do this at the end of every module

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"What we say and what we do ultimately comes back to us, so let us own our responsibility, place it in our own hands and carry it with dignity and strength."

- Gloria Anzaldua

52

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Notes to Trainer: Ask participants to hold this as we continue training today.

January 12, 2014: An Open Letter to Women Writers of Color by Gloria Evangelina Anzaldúa

Module 2: Domestic Violence, Perinatal Health, and Reproductive Coercion: Definitions and Dynamics

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Module 2

Domestic Violence, Perinatal Health, and Reproductive Coercion: Definitions and Dynamics

Estimated Module Time: 90 minutes

(Depending on the amount of discussion time and activities)

This module is recommended if your audience has not had previous training on domestic violence or would benefit from an overview of introductory content on domestic violence. We recommend that participants contact their local domestic violence advocates for more in-depth, comprehensive training on domestic violence.

Training Outline

- Learning objectives
- Magnitude of problem, definitions, and key concepts
- Culture and domestic violence
- Validation and supportive messages

Overview

The module begins with statistics about how common domestic violence is. This is followed by several key definitions and a handout of the Power and Control Wheel to help participants recognize the many different forms of abuse that can occur within intimate relationships.

Learning Objectives

After this training, participants will be better able to:

1. Describe the prevalence of domestic violence.
2. List two ways domestic violence affects perinatal health.
3. Give two examples of reproductive coercion.
4. Describe a tool developed to educate clients about reproductive coercion.

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Notes to Trainer: Read the learning objectives aloud.

Notes to Trainer: Home visitors face unique challenges and risks when working with families who are experiencing domestic violence. Home visitors may see things while visiting clients in their homes that other service providers working with the same family are not aware of, such as: escalating tension, threatening behaviors, and signs of violence (broken furniture, a hole in the wall, etc.). Because a home visitor may be in the home when physical violence erupts, it is essential that home visitation programs have a safety protocol for staff to follow when they are working with families experiencing domestic violence.

Resource: Model Home Safety Protocol, Appendix D.

Getting Started: Small Group Discussion

Why is it important for home visitors to know about domestic violence?

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Estimated Activity Time: 10 minutes

Notes to Trainer:

1) Ask participants to discuss this question for five minutes, breaking up into small groups, if feasible. Instruct groups to prepare a brief answer, consisting of two sentences.
2) Ask each group to share their answers.
3) Go to the next slide which describes how domestic violence is connected to the goals of many programs that provide home visitation services

Notes to Trainer: These are common goals among many home visitation programs. There is an extensive body of research that has shown how domestic violence is connected to each of these outcomes. These connections will be described in this training.

Lessons Learned from Nurse Family Partnership

The effectiveness of home visitation services in preventing child abuse is diminished and may even disappear when mothers are being victimized by an intimate partner.

(Eckenrode, et al. 2000)

58

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Notes to Trainer: In a 15-year follow-up of the Nurse Family Partnership model, a home visitation program that has been shown to reduce child maltreatment, the treatment affect of home visits on reducing verified child abuse maltreatment reports decreased as the frequency of IPV increased.

Eckenrode J, Ganzel B, Henderson C, Smith E, Olds D, Powers J, Cole R, Kitzman H, Sidora K. (2000). Preventing Child Abuse and Neglect with a Program of Nurse Home Visitation: The Limiting Effects of Domestic Violence. *Journal of the American Medical Association.* 284(11): 1385-1391.

Before we learn about the dynamics of DV, let's talk about your personal safety.

- Does your program currently have a protocol to promote staff safety on home visits?
- What kinds of things are included in your protocol?
- What other things do you do to keep yourself safer?

59

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Estimated Activity Time: 10 minutes

Notes to Trainer: Using a flip chart, repeat and record the answers given by the audience.

Other service providers that work with families experiencing domestic violence and have contact with families in their homes may have protocols and safety strategies that could be helpful for home visitors. Inviting service providers such as police officers and child protection workers to do a brown bag lunch training provides the opportunity for cross-training and builds partnerships between agencies that are often working with the same families.

Personal Safety Strategies for Home Visitors

- Trust your instincts
- Meet with the client at the office if the situation does not feel safe at their home
- Park vehicle pointed toward exit
- Observe and listen before entering a household
- Enter household **ONLY** if you see the client at the door
- Position yourself near the door/exit in the household
- Have emergency numbers programmed into your cell phone and set on auto-dial
- Consider adopting a model protocol for your program (see Appendix D)

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Notes to Trainer: Hand out print out of Appendix D: Model home safety protocol. If the earlier discussion did not cover any of these key safety ideas please review them with the audience. One strategy that might be useful is to have a coworker call 5 minutes into the visit to give you an excuse to leave if you are feeling unsafe. If this happens, please follow up at the next visit with the client. Be authentic and explain to client why you engaged in a safety activity (leaving suddenly or making an excuse to leave)—often clients give home visitors pointers on how to be safer. The client will appreciate the check in.

These safety strategies are discussed along with other practical lessons learned about working with domestic violence within the context of home visits in the following publication, *Addressing Domestic Violence within the Context of Home Visitation by Linda Chamberlain.*

Chamberlain, L. 2008. Addressing Domestic Violence within the Context of Home Visitation. *Journal of Emotional Abuse;* 8:205-216.

Sticker Exercise

What is domestic violence? What does it include?

At your table, write down five examples for one category.
Personalize it with examples you have seen in home visitation.

1. Physical
2. Sexual
3. Emotional
4. Economic

61

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Notes to Trainer: Ask participants to follow the instructions on slide. Assign each group one of the four categories. Ask for volunteers to share what their team wrote.

A great example of something that came up around the Sexual category is from a home visitor in Illinois who said, “My client told me that her partner told her that she had to have sex with him everyday to keep the baby healthy during pregnancy.”

Definitions of Domestic Violence

- Legal definitions are often more narrowly defined with particular focus on physical and sexual assault
- Public health definitions include a broader range of controlling behaviors that impact health including:

Emotional abuse, social isolation, stalking, intimidation and threats

62

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Notes to Trainer: Advise participants that a definition of reproductive coercion will be provided during this presentation. For CDC's definition of domestic violence, refer here: www.cdc.gov/violenceprevention/intimatepartnerviolence/

Prevalence of Domestic Violence

1 in 4 (25%)

U.S. women report having experienced physical and/or sexual violence by a partner.

(Black et al, 2011)

63

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Notes to Trainer: Many of the participants have likely seen these statistics. With data slides such as this one, try to make the connection to the participant's practice. For example, "this means that if you see 20 women a day, it is likely that at least 5 of them have experienced physical violence in their relationship…and this doesn't even begin to reflect those who experience verbal, psychological or emotional abuse or sexual coercion…"

You can also ask participants to look at these numbers in relationship to other chronic conditions or illnesses. One in three women is obese, one in five is a smoker, and one in four women will experience intimate partner violence in her lifetime.

Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

What We Know

14% - 52% of home visited perinatal clients experienced domestic violence in the past year.

(Sharps et al, 2008)

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Notes to Trainer: Sharps and colleagues identified eight studies that assessed DV and used home visitation during the perinatal period. All of the studies are described in a detailed table in the publication by Sharps et al., 2008.

The considerable variation in estimates of prevalence among home-visited perinatal clients is influenced by many factors including whether assessment was routinely implemented, how often the questions were asked, what type of questions/assessment tool was used, how the questions were asked, whether home visitors received training on screening and their comfort level with screening, and differences in the study populations.

Sharps PW, Campbell J, Baty ML, Walker KS, Bair MH. (2008). Merritt Current Evidence on Perinatal Home Visiting and Intimate Partner Violence. *J Obstet Gynecol Neonatal Nurs,* 37(4):480-491.

Intimate Partner Sexual Assault

1 in 5 (20%) women in the U.S. has been raped at some time in their lives and half of them reported being raped by an intimate partner.

(Black et al, 2011)

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Notes to Trainer: All experiences of sexual violence including rape impact sexual and reproductive health. While many home visitors likely have some knowledge that intimate partner sexual violence happens, some may not realize the extent to which it does. It's important that home visitors, who may just focus on physical and emotional abuse, expand their assessment to include intimate partner sexual violence as well.

Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

African American, Native American, and Hispanic women are at significantly greater risk for domestic violence.

(Tjaden, P., & Thoennes, N. 2000 and others.)



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Bureau of Justice Statistics Homicide Trends in the U.S.: Trends in Intimate Homicides Source: FBI, Supplementary Homicide Reports, 1976-2005. (Available at: www.ojp.usdoj.gov/bjs/homicide/intimates.htm)

Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence, United States, 2005, MMWR February 8, 2008/ 57(05); 113-117. www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm

Tjaden, P., & Thoennes, N. (2000). Full report of the prevalence, incidence, and consequences of violence against women. U.S. Department of Justice.

Health Disparities Issue

When differences in income, education and/or employment are considered, the differences attributable to race for DV decrease or disappear.

(Jones et al, 1999; Tjaden & Thoennes, 2000; Walton-Moss et al, 2005)

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Notes to Trainer: Some studies show that African American, Native American, and Latina women experience higher rates of domestic violence while others find that when socioeconomic status is controlled for ethnic differences the higher rates of violence are reduced or eliminated.

Jones. A.S., Campbell, J.C., Schollenberger, J., O'Campo, P.J., Dienemann, J.A., Gielen, A.C., Kub, J., &Wayne, E.C. (1999). Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. *Women's Health Issues,* 9(6), 295-305.

Tjaden, P. & Thoennes, N. (2000). Extent, nature and consequences of intimate partner violence: Findings from the national violence against women survey. Washington, D.C.: US Department of Justice, NCJ 181867.

Walton-Moss, B. J., Manganello, J., Frye, V. & Campbell, J.C. (2005). Risk factors for intimate partner violence and associated injury among urban women. *Journal of Community Health,* 30, 377-389.

Cho, H. (2012). Racial Differences in the Prevalence of Intimate Partner Violence Against Women and Associated Factors. *Journal of Interpersonal Violence,* 27(2), 344-363. doi: 10.1177/0886260511416469

Domestic Violence cuts across all races, cultures, ethnicities, religions, sexual orientations, age groups, and socioeconomic levels.

Every culture has elements that ***condone*** domestic violence and elements that ***resist*** it

(Mitchell et al, 2007; Tjaden and Thoennes, 2000)

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Notes to Trainer: Anyone can be a victim of domestic violence regardless of: age, race, ethnicity, sexual orientation, religion, class, immigration status, disability, and/or region (rural/urban). Every culture has elements that condone men's controlling behavior of women and some line differentiating what level of abuse is considered acceptable from what level is considered unacceptable. For example, under certain circumstances, minor violence such as pushing or shoving might be condoned, while abuse beyond that level is considered unacceptable.

Shelter from the Storm, a curriculum for mental health clinicians who work with children exposed to domestic violence, raises the point that ethnic/cultural background may influence any of the following factors when domestic violence is present:

- The batterer's tactics
- The survivor's coping strategies
- Community response
- Institutional response
- The individual meaning of violence
- The quality of the service provider-client relationships

Mitchell SJ, See HM, Tarkow AKH, Cabrera N. Conducting Studies with Fathers: Challenges and Opportunities Applied Development Science 2007, Vol. 11, No. 4, 239-244.

Tjaden P, Thoennes N. Extent, Nature, and Consequences of Intimate Partner Violence. U.S. Department of Justice, Offices of Justice Programs, National Institute of Justice. Washington, DC. July, 2000.

Impact of Psychological Abuse

Psychological abuse by an intimate partner was a stronger predictor than physical abuse for the following health outcomes for female and male victims:

- Depressive symptoms
- Substance use
- Developing a chronic mental illness

(Coker et al, 2002)

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69

Notes to Trainer: Ask participants, how many of your programs are using screening tools that look at physical abuse only? Explain that the Relationship Assessment Tool, Appendix G, that we will go over this afternoon was the evidenced-based screening tool chosen for the curriculum because it addressed this truth. In this study:

- Women were significantly more likely than men to experience physical or sexual abuse and abuse of power and control by an intimate partner compared to men.
- Both physical and psychological abuse by an intimate partner were associated with significant physical and mental health problems for male and female victims.

Coker AL, Smith PH, Thompson MP, McKeown RE, Bethea L, Davis KE. (2002) Social Support Protects Against the Negative Effects of Partner Violence on Mental Health. *Journal of Women's Health & Gender-Based Medicine.* 11(5):465-476.

Group Discussion

Why might a woman stay in a relationship when domestic violence has occurred?

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Estimated Activity Time: 2 minutes

Notes to Trainer: This is a quick question and answer session for the audience. Remind the audience that we are focusing on teens and adults who are experiencing abusive behaviors that are perpetrated by their intimate partners. There would be other reasons and circumstances if we were talking about children who were being physically or sexually abused by a parent or other adult.

Some reasons why women stay:

- Because she loves him and has hope that he will change
- Lack of safe alternatives for herself and children
- Lack of family or community support
- Lack of money or loss of status if she leaves
- Women do leave—but leaving is a process
- In some cases, the violence does end

Perinatal Health

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How does domestic violence impact women's perinatal health and their birth outcomes?

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Activity Time: 15 minutes

Notes to Trainer: For this activity, you will need a flipchart and markers. Ask participants to call out responses to the question, **"How does domestic violence impact women's perinatal health and their birth outcomes?"**

Repeat the participants' responses, clarify as needed and give hints about what is missing. For example, if depression has not been mentioned the facilitator could, say "So let's talk about how this might impact moms' feelings or emotional health…"

If you are working with another trainer, one of you should be the note-taker. The note-taker records what the participants call out onto the flipchart and then tapes sheets when they are full around the room so the responses can be seen by the audience.

When the trainer feels that some of the key effects have been identified, move forward through the next slides in this module to review and highlight examples that were given, as well as anything that was missing.

Homicide is the second leading cause of injury-related deaths among pregnant women.

(Chang et al, 2005)

73

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Notes to Trainer: Inform participants that a majority of female homicides are women who were murdered by a current or former intimate partner.

Pregnancy-associated homicides were analyzed with a national dataset (1991-1999) from the Pregnancy Mortality Surveillance System at the Centers for Disease Control and Prevention for this study. Pregnancy-associated injury deaths and homicides were defined as women who died during or within one year of pregnancy.

Of all pregnancy-associated injury deaths, motor vehicle accidents was the leading cause (44.1%) and homicide was the second leading cause (31.0%). The rest of the pregnancy-associated injury deaths were attributed to unintentional injuries (12.7%), suicides (10.3%), and other (2.0%).

Chang J, Berg CJ, Saltzman LE, Herndon J. (2005). Homicide: A Leading Cause of Injury Deaths Among Pregnancy and Postpartum Women in the United States, 1991-1999. *American Journal of Public Health.* 95(3):471-477.

Complications During Pregnancy: Teens

Pregnant teens who experienced abuse were **more likely** to miscarry than their non-abused peers.

(Jacoby et al,1999)

Prenatal violence was a **significant risk** factor for pre-term birth among pregnant adolescents.

(Covington et al, 2001)

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Notes to Trainer: In this population, the experience of any form of physical or sexual violence during the study interval was associated with rapid repeat pregnancy (RRP) within 12 months ($p = 0.01$, OR = 3.46) and 18 months ($p = 0.013$, OR = 4.29). Other previously reported predictors of RRP, including family stress, financial stress, and other environmental stressors did not reach statistical significance at either 12 months or 18 months in this sample. Of additional note, young women who experienced any form of abuse during the 12-month study interval were substantially more likely to miscarry than were their nonabused peers, and spontaneous abortion was also very strongly associated with RRP ($p < 0.00001$; OR = 22.6).

Jacoby, M, Gorenflo D, Black E, Wunderlich C, Eyler AE. (1999). Rapid repeat pregnancy and experiences of interpersonal violence among low-income adolescents. *Am J Prev Med.* 16(4):318-21.

The prospective cohort study included all program participants from 1994 to 1996. Care coordinators screened participants for physical violence during pregnancy using a validated, systematic assessment protocol three times during prenatal care. The protocol was linked with prenatal records, delivery records and infant records to document complications and infant outcomes. Multiple logistic regression was used to assess the relationship between severe physical violence during pregnancy and pregnancy outcome while controlling for confounding factors.

Covington DL, Hage M, Hall T, Mathis M. (2001). Preterm delivery and the severity of violence during pregnancy. *J of Repro Med*. 46(12):1031-9.

Physical DV in the 12 Months Prior to Pregnancy Increases the Risk of:

- High blood pressure or edema
- Vaginal bleeding
- Severe nausea, vomiting, or dehydration
- Kidney infection or urinary tract infection
- Placental abruption
- Preterm birth

(Silverman et al, 2006)

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75

Notes to Trainer: Data from women giving birth in 26 U.S. states and participating in the 2000 to 2003 Pregnancy Risk Assessment Monitoring System (n = 118,579) were analyzed.

RESULTS: Women reporting intimate partner violence in the year prior to pregnancy were at increased risk for high blood pressure or edema (adjusted odds ratio 1.37-1.40), vaginal bleeding (adjusted odds ratio 1.54-1.66), severe nausea, vomiting or dehydration (adjusted odds ratio 1.48-1.63), kidney infection or urinary tract infection (adjusted odds ratio 1.43-1.55), hospital visits related to such morbidity (adjusted odds ratio 1.45-1.48), and delivery preterm (adjusted odds ratio 1.37), of a low-birth weight infant (adjusted odds ratio 1.17) and an infant requiring intensive care unit care (adjusted odds ratio 1.31-1.33) compared with those not reporting intimate partner violence. Women reporting intimate partner violence during but not prior to pregnancy experienced higher rates of a subset of these concerns.

Silverman JG, Decker MR, Reed E, Raj A. (2006). Intimate partner violence victimization prior to and during pregnancy among women residing in 26 U.S. states: associations with maternal and neonatal health. *Am J Obstet Gynecol.;* 195(1):140-8. Epub 2006 Apr 21.

Women who experience abuse around the time of pregnancy are more likely to:

- Smoke tobacco
- Drink during pregnancy
- Use drugs
- Experience depression, higher stress, and lower self-esteem
- Attempt suicide
- Receive less emotional support from partners

(Bailey & Daugherty, 2007; Martin et al, 2006; Martin et al, 2003; Curry, 1998; Martin et al, 1998; Perham-Hester & Gessner, 1997; McFarlane et al, 1996; Berenson et al, 1994; Campbell et al, 1992; Amaro, 1990)

FUTURES WITHOUT VIOLENCE

Notes to Trainer: Experiencing domestic violence around the time of pregnancy has been shown to be associated with substance abuse, mental health problems, and other risk behaviors that are associated with poor pregnancy outcomes.

Amaro H, Fried LE, Cabral H. Zuckerman B. (1990). Violence During Pregnancy and Substance Use. *American Journal of Public Health.* 80(5):575-579.

Bailey BA, Daugherty RA. (2007). Intimate Partner Violence During Pregnancy: Incidence and Associated Health Problems in a Rural Population. *Maternal and Child Health Journal.* 11(5):495-503.

Berenson AB, Wiemann CM, Wilkinson GS, Jones WA, Anderson GD. (1994). Perinatal Morbidity Associated with Violence Experienced by Pregnant Women. *American Journal of Obstetrics and Gynecology.* 170:1760-1769.

Campbell JC, Poland ML, Waller JB, Ager J. (1992). Correlates of Battering During Pregnancy. *Research in Nursing and Health.* 15:219-226.

Curry MA. (1998). The Interrelationships Between Abuse, Substance Use, and Psychosocial Stress During Pregnancy. *JOGNN.* 27(6):692-699.

Martin SL, Beaumont JL, Kupper LL. (2003). Substance Use Before and During Pregnancy: Links to Intimate Partner Violence. *American Journal of Drug and Alcohol Abuse.* 29:599-617.

Martin SL, Kilgallen B, Dee DL, Dawson S, Campbell JC. (1998) Women in Prenatal Care/Substance Abuse Treatment Programme: Links between Domestic Violence and Mental Health. *Journal of Maternal and Child Health.* 2:85-94.

McFarlane J, Parker B. Soeken K. (1996) Physical Abuse, Smoking and Substance Abuse During Pregnancy: Prevalence, Interrelationships and Effects on Birth Weight. *Journal of Obstetrics, Gynecology and Neonatal Nursing.* 25:313-20.

Perham-Hester KA, Gessner BD. (1997) Correlates of Drinking During the Third Trimester of Pregnancy in Alaska. *Maternal and Child Health Journal.* 1(3): 165-17

Tobacco Cessation and DV: Redding Story

42% of women experiencing some form of IPV could not stop smoking during pregnancy compared to **15%** of non-abused women.

(Bullock et al, 2001)

77

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Notes to Trainer: In this retrospective study by Bullock et al. (2001), rural postpartum women (n=293) were interviewed during their hospital stay about their tobacco use and experiences with DV. DV was measured with the Abuse Assessment Screen which includes questions on physical, sexual, and emotional abuse within the past year and since pregnancy. The rate of smoking among abused women during pregnancy is in agreement with other **prospective studies** that found between **44% and 60%** of abused women continue to smoke during pregnancy.

Read aloud: The Redding story that is referred to in the title of this slide is the story of a woman that the authors of this curricula, Linda and Rebecca, often tell when they train. Upon asking a woman who was a 3 pack-a-day smoker if she thought experiences with domestic violence might be connected to her smoking she said, "You don't understand. Smoking was the only thing I could control. I didn't get to use the phone or the car or see my family without permission. I didn't go to the store or spend any money without permission—smoking was the ONLY thing I controlled." So suddenly a story like this helps us to understand why a referral to smoking cessation might not be affective for a woman experiencing abuse. I think this story lends itself to larger compassion for some of the clients we serve who have addiction issues.

Bullock LFC, Mears JLC, Woodcock C, Record R. (2001) Retrospective Study of the Association of Stress and Smoking During Pregnancy in Rural Women. *Addictive Behaviors.* 26:405-413.

DV during pregnancy is associated with:

- Lower gestational weight gain during pregnancy

(Morales et al, 2006)

- Low and very low birth weight

(Lipsky et al, 2003)

- Pre-term births

(Silverman et al, 2006; Valladares et al, 2003)

FUTURES WITHOUT VIOLENCE

Notes to Trainer: Numerous studies have documented the impact of domestic violence on pregnancy. An overview of the effects of domestic violence on women's reproductive health and pregnancies can be found in a review study by Sarkar (2008).

Lipsky S, Holt VL, Esterling TR, Critchlow C. (2009) Police-Reported Intimate Partner Violence During Pregnancy and Risk of Antenatal Hospitalization. *Maternal and Child Health Journal.* 8(2):55-63.

Morales CL, Amorim AR, Reichenheim ME. (2006) Gestational Weight Gain Differentials in the Presence of Intimate Partner Violence. *International Journal of Gynaecology and Obstetrics*. 95:254-260.

Silverman JG, Decker MR, Reed E, Raj A. (2006) Intimate Partner Violence Victimization Prior to and During Pregnancy Among Women Residing in 26 U.S. States: Associations with Maternal and Neonatal Health. *American Journal of Obstetrics and Gynecology.* 195:140-148.

Sarkar NN. (2008) The Impact of Intimate Partner Violence on Women's Reproductive Health and Pregnancy Outcome. *Journal of Obstetrics and Gynaecology.* 28(3):266-271.

Breastfeeding In Alaska: Linda's Story

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Notes to Trainer: Linda Chamberlain, an epidemiologist specializing in domestic violence who works for public health in the state of Alaska, shared a story number of years ago that is incredibly powerful. She was contacted by the obstetrics unit of a large hospital to come and talk to home visitors about why women were not breastfeeding.

Pose this question to the audience: *What was the biggest reason women gave for not breastfeeding?*

This is a great question because Linda didn't know anything about breastfeeding and at first could not figure out why the hospital had asked for her help. The answer to the question is domestic violence. The hospital informed her that every new mother who chose not to breastfeed was asked why, and the leading reason disclosed was domestic violence. It's important to note that these disclosures were made before the hospital implemented routine screening for IPV. The hospital's observations led to training, protocol development and routine screening during and after pregnancy. And since then, research has substantiated this connection.

DV and Breastfeeding

Women experiencing physical abuse around the time of pregnancy are:

- **35%-52%** less likely to breastfeed their infants
- **41%-71%** more likely to cease breastfeeding by 4 weeks postpartum

(Lau & Chan, 2007; Silverman et al, 2006)

FUTURES WITHOUT VIOLENCE

Notes to Trainer: This study analyzed data from 26 U.S. states that participated in the 2000-2003 Pregnancy Risk Assessment Monitoring System (PRAMS).

Domestic violence (DV) was measured by two questions as follows:

- "During the 12 months before you got pregnant, did your husband or partner push, hit, slap, kick, choke or physically hurt you in any other way?"
- "During your most recent pregnancy, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?"

Women who reported DV in the year prior to pregnancy but not during pregnancy, women who reported DV during pregnancy but not in the year prior to pregnancy, and women who reported DV during the year prior to pregnancy and during pregnancy were significantly less likely to breastfeed their infants.

Silverman JG, Decker MR, Reed E, Raj A. (2006). Intimate Partner Violence Victimization Prior to and During Pregnancy Among Women Residing in 26 U.S. States: Associations with Maternal and Neonatal Health. *American Journal of Obstetrics and Gynecology*. 195:140-148.

Postpartum Maternal Depression

Women with a controlling or threatening partner are

5 times

more likely to experience persistent symptoms of postpartum maternal depression.

(Blabey et al, 2009)

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81

Notes to Trainer: This data is from the Alaska Pregnancy Risk Assessment Monitoring System (PRAMS). Women completed a survey within a few months after delivery and were then contacted again approximately two years later.

Blabey MH, Locke ER, Goldsmith YW, Perham-Hester KA. (2009) Experience of a Controlling or Threatening Partner Among Mothers with Persistent Symptoms of Depression. *American Journal of Obstetrics & Gynecology.* 201:173.e1-9.

Group Discussion

Take a moment to consider the slides you just reviewed, did any of them give you an "ah ha" moment?

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82

Estimated Activity Time: 2 minutes

Notes to Trainer: This is a quick question and answer session for the audience.

Notes to Trainer: As a home visitor, when you see your client they are already pregnant. However, home visitors can help clients prevent unwanted pregnancy in the future.

Show of Hands

What percentage of your clients' pregnancies have been unplanned?

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Estimated Activity Time: 2 minutes

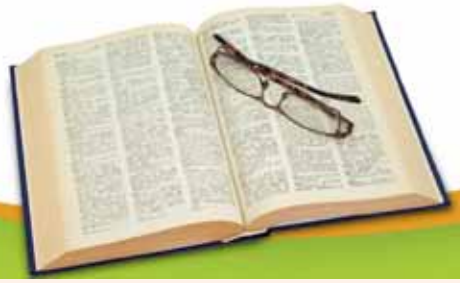
Notes to Trainer: Ask participants what percent of clients have unplanned pregnancies versus planned pregnancies. (Please Note: you may want to underscore the difference between unplanned versus unwanted—we are just talking about unplanned here). Ask them to identify the option they believe by a show of hands. Ask participants to keep their hands in the air. Begin with 10% and go higher until 90% or over.

Finally, ask the audience if they have ever considered that pregnancy might have something to do with reproductive coercion.

Reproductive Coercion (RC) involves behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. More specifically, RC is related to behaviors that interfere with contraception use and/or pregnancy.

These behaviors may include:

- Explicit attempts to impregnate a partner against her wishes
- Controlling outcomes of a pregnancy
- Coercing a partner to have unprotected sex
- Interfering with birth control methods



FUTURES WITHOUT VIOLENCE

Notes to Trainer: Read the definition of reproductive coercion aloud.

Futures Without Violence. Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, and Reproductive Health Care Settings. Third Edition. San Francisco (CA): FUTURES; 2013. Available at: www.futureswithoutviolence.org/integrating-health-services-into-domestic-violence-programs-tools-for-advocates/

DV increases women's risk for

UNINTENDED PREGNANCIES

(Sarkar, 2008; Goodwin et al, 2000; Hathaway et al, 2000)

FUTURES WITHOUT VIOLENCE

Notes to Trainer: Sarkar conducted a literature review of publications from 2002 through 2008 on the impact of domestic violence on women's reproductive health and pregnancy outcomes.

In a study by Goodwin et al (2000), women who had unintended pregnancies were 2.5 times more likely to experience physical abuse compared to women whose pregnancies were intended.

Hathaway et al. (2000) analyzed data from a population-based survey (Behavioral Risk Factor Surveillance System) in Massachusetts to examine the association between IPV and unintended pregnancy. Among women experiencing IPV who had been pregnant in the past 5 years, approximately 40% reported that the pregnancy was unwanted, as compared to 8% of other women.

Miller E, Levenson R, Jordan B, Silverman JG. (2010). Reproductive coercion: connecting the dots between partner violence and unintended pregnancy. *Contraception,* 81(6):457-9.

Sarkar NN. (2008). The Impact of Intimate Partner Violence on Women's Reproductive Health and Pregnancy Outcome. *Journal of Obstetrics and Gynaecology,* 28(3):266-271.

Goodwin MM, Gazmararian JA, Johnson CH, Gilbert BC, Saltzman LE. (2000). Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996-1997. PRAMS Working Group. Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal,* 4(2):85–92.

Hathaway J, Mucci L, Silverman J, Brooks D, Matthews R, and Pavlos C. (2000). Health status and health care use of Massachusetts women reporting partner abuse. *American Journal of Preventive Medicine,* 19:302-307.

Adolescent Pregnancy and IPV

Adolescent girls in physically abusive relationships were

3.5 times

more likely to become pregnant than non-abused girls.

(Roberts et al, 2005)

FUTURES WITHOUT VIOLENCE

Notes to Trainer: Pose this question to the audience: *Is this something the average American thinks about when they think about teen pregnancy?*

A large body of research points to the connection between abuse and teen pregnancy. However, few teen pregnancy programs address the connection between abuse and pregnancy risk, or recognize the identification of one of these risks as a clinical indicator to screen for the other. It may be interesting for the participants to consider what we associate with teen pregnancy from the media.

This study by Roberts and colleagues (2005) analyzed data from the National Longitudinal Study of Adolescent Health. The analyses adjusted for sociodemographic factors, the number of intimate partners, and a history of forced sexual intercourse. A past history or current involvement in a physically abusive relationship was associated with a history of being pregnant among sexually active adolescent girls. Physical abuse was defined as "push you," "shove you," or "throw something at you."

In a study by Silverman et al. (2001), adolescent girls who experienced physical or sexual dating violence were 6 times more likely to become pregnant than their non abused peers.

Roberts TA, Auinger MS, Klein JD. (2005). Intimate partner abuse and the reproductive health of sexually active female adolescents. *Journal of Adolescent Health,* 36:380-385.

Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association,* 286(5): 572-579.

Domestic violence increases women's risk for:

- Unintended pregnancies
- Rapid repeat pregnancy
- HIV
- Sexually transmitted infections

(Sarkar, 2008; Raneri & Wiemann, 2007; Decker, 2005; Wu et al, 2005)

FUTURES WITHOUT VIOLENCE

Notes to Trainer: Sarkar conducted a literature review of publications from 2002 through 2008 on the impact of domestic violence on women's reproductive health and pregnancy outcomes.

In a study by Goodwin et al (2000), women who had unintended pregnancies were 2.5 times more likely to experience physical abuse compared to women whose pregnancies were intended.

Sarkar NN. (2008) The Impact of Intimate Partner Violence on Women's Reproductive Health and Pregnancy Outcome. *Journal of Obstetrics and Gynaecology.* 28(3):266-271.

Goodwin MM, Gazmararian JA, Johnson CH, Gilbert BC, Saltzman LE. (2000) Pregnancy Intendedness and physical abuse around the time of pregnancy: Findings form the pregnancy risk assessment monitoring system, 1996-1997. *Matern Child Health J.* 4(2):85-92

PRAMS Working Group. (2000). Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal.* 4(2):85-92.

Wu E, El-Bassel N, Witte S, Gilbert L, Chang M. (2003). Intimate Partner Violence and HIV Risk Among Urban Minority Women in Primary Health Care Settings. *AIDS and Behavior.* 7(3):291-301.

Decker MR, Silverman JG, Raj A. (2005). Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis among Adolescent Females. *Pediatrics.* 116(2):e272-276.

Silverman JG, Raj A, Mucci LA, Hathaway JE. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association.* 286(5): 572-579.

Adolescent mothers who experienced physical abuse within three months after delivery were **nearly twice** as likely to have a repeat pregnancy within 24 months

(Raneri, et al, 2007)

89

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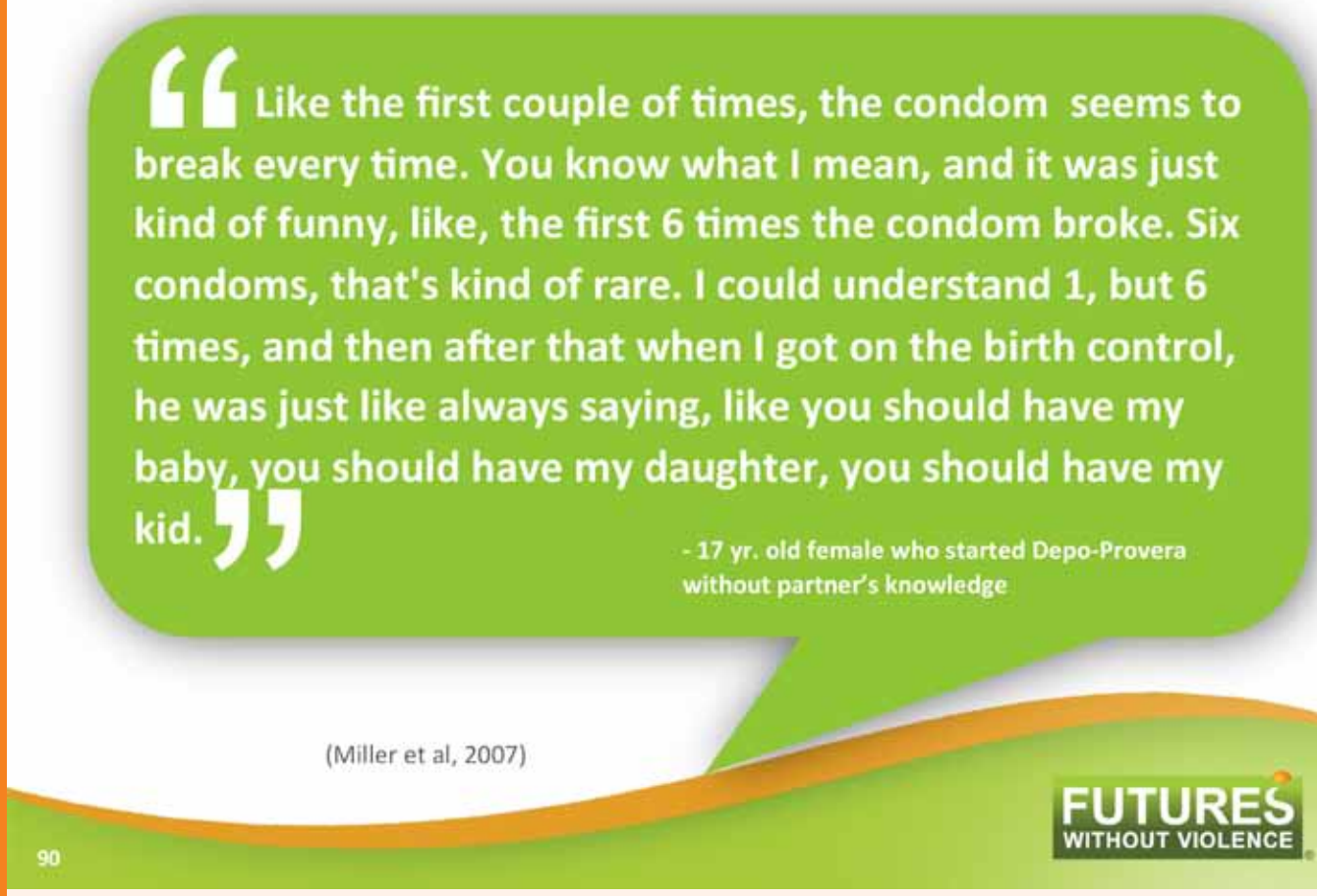
Notes to Trainer: In this study with teenage mothers (ages 12-18) who were recruited from a labor and delivery unit at a university hospital, physical abuse by an intimate partner was defined as being hit, slapped, kicked, or physically hurt enough to cause bleeding or having been hit during an argument or while her partner was drunk or high.

The odds of repeat pregnancy was 1.9 times higher among teen mothers who were physically abused by their partner within three months of delivery compared to non-abused teen mothers.

Raneri LG, Wiemann CM. (2007) Social Ecological Predictors of Repeat Adolescent Pregnancy. *Perspectives on Sexual and Reproductive Health.* 39(1):39-47.

Pregnancy Pressure and Condom Manipulation



Notes to Trainer: Read this aloud. Pose the question to the audience: *Do you think the condom broke accidentally 6 times?* Let the audience answer.

How do we know this wasn't accidental? Look at the last line again (Trainer should reread last line again for emphasis). This quotation is from a qualitative study by Miller et al. (2007) on male pregnancy-promoting behaviors and adolescent partner violence. The teen girl was parenting a baby from a different relationship and the abusive relationship started shortly after she broke up with her son's father. She went to a teen clinic and started Depo-Provera injections without her new partner's knowledge.

Miller E, Decker MR, Reed E, Raj A, Hathaway JE, Silverman JG. (2007) Male Partner Pregnancy-Promoting Behaviors and Adolescent Partner Violence: Findings From a Qualitative Study with Adolescent Females. *Ambulatory Pediatrics.* 7(5):360-366.

What are other ways a partner can interfere with a female client's birth control?

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Estimated Activity Time: 3 minutes

Notes to Trainer: Ask participants to give some examples they have seen in their DV programs. Responses may include examples of condom refusal, pregnancy pressure, forced sex, etc. Proceed to the next slide which provides examples of birth control sabotage and highlight any examples that were not identified by participants.

Can Men Experience Reproductive Coercion?

Yes, and there are gendered differences about the impact of this on men's and women's lives.

- A female partner could lie about contraceptive use and he could become a father as a result.

Question to consider: Were there threats or harm?

- To date there have been no studies indicating men have become fathers when they didn't want to be because she threatened to kill him if he didn't get her pregnant.

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Notes to Trainer: Adolescent and adult males may also experience reproductive and sexual coercion. A recent national survey on intimate partner and sexual violence in the United States provided the first population based data on males' experiences with reproductive and sexual coercion.

- Approximately 10.4% (or an estimated 11.7 million) of men in the United States reported ever having an intimate partner who tried to get pregnant when they did not want them to or tried to stop them from using birth control, with 8.7% having had an intimate partner who tried to get pregnant when they did not want them to or tried to stop them from using birth control
- 6% of men have experienced sexual coercion in their lifetime (i.e., unwanted sexual penetration after being pressured in a nonphysical way)

Black MD, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.* Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

How many of you think about domestic violence when you hear about teen pregnancy?

Among teen mothers on public assistance who experienced recent domestic violence:

66% experienced birth control sabotage by a dating partner

(Raphael, 2005)

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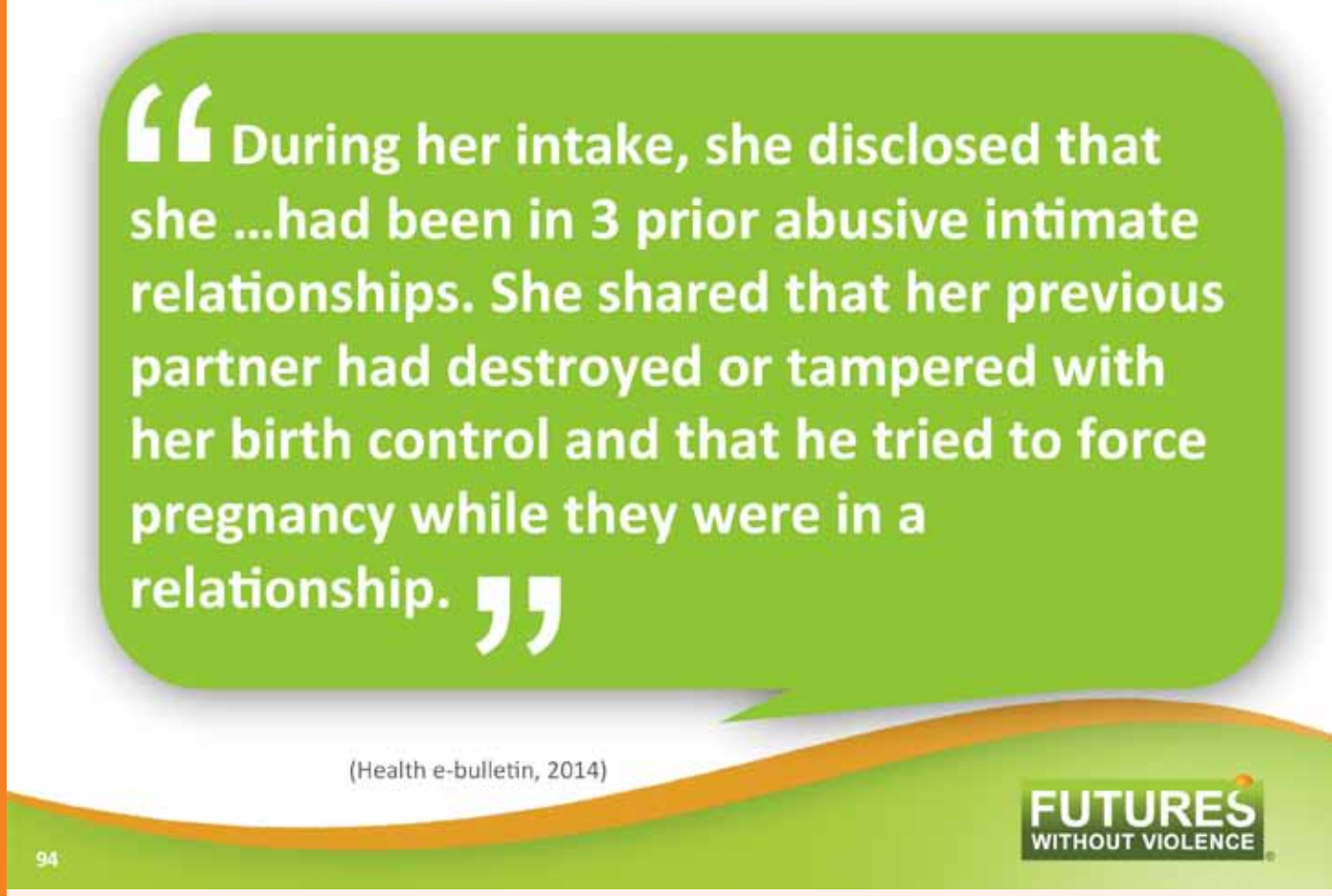
93

Notes to Trainer: In this study by Raphael (2005), 474 teen girls on Temporary Assistance to Needy Families completed written surveys. The teens were recruited from two state-funded Teen Parent Services sites and two community-based health clinics. Seventy percent were between the ages of 15 and 17 at the time of the birth of their first infant (mean =18 years) and 95% of the girls were African Americans. Almost half (43%) of the girls were involved with males who were older by 4 or more years. Fifty-five percent disclosed domestic violence in the past 12 months. Findings included:

- Two-thirds (66%) of teen dating violence victims experienced birth control sabotage compared to 34% of non-abused teens
- 34% of teen dating violence victims reported work or school related sabotage compared to 7% of teens who did not experience dating violence but were sabotaged in relation to work or school.

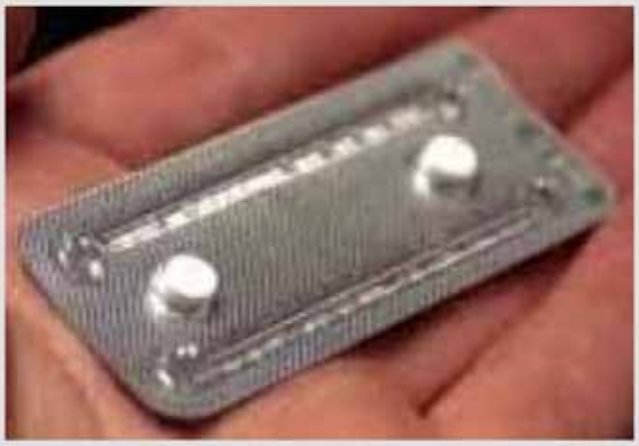
Raphael J. (2005) Teens Having Babies: The Unexplored Role of Domestic Violence. *The Prevention Researcher.* 12(1):15-17.

Stories From Home Visitors



National Health Resource Center on Domestic Violence, Health e-bulletin summer 2014, p 9. Available at: www.futureswithoutviolence.org/userfiles/FWV_eBulletin_2014_R3_071720142.pdf

Emergency Contraception and IPV



Abused women are more likely to have used emergency contraception when compared to non-abused women.

(Gee et al, 2009)

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Notes to Trainer: The women in this study experiencing IPV were more likely to have used after-the-fact emergency contraception either in the past or to prevent a current pregnancy.

Rebekah E. Gee, MD, MS, MPH, Nandita Mitra, PhD, Fei Wan, MS, Diana E. Chavkin, MD, Judith A. Long, MD. (2009) Power over parity: intimate partner violence and issues of fertility control. *Am J Obstet Gynecol*. 201:148.e1-7.

Emergency Contraception Education

The following video clip explains how emergency contraception works.

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Estimated Activity Time: 2 minutes to watch video and 5 minutes for discussion

Notes to Trainer: Introduce the video. Be sure to note that it was developed in partnership with both domestic violence advocates and reproductive health home visitors. It includes real life comments and experiences that were encountered as domestic violence programs began addressing reproductive health issues as part of safety planning.

Ask participants:

- What worked well?
- What would you change?
- Are there considerations or questions specific to your setting that might make this safety card more useful?

Notes to Trainer: *This can be controversial. It's important to not get in the weeds but simply lay out the facts.* Acknowledge that there is a lot of misinformation about Emergency Contraception. The Food and Drug administration determined this medication was safe enough that it could be sold over the counter in the pharmacy.

Some home visitors may not think it is their role to talk about medical issues like EC—but ask the audience to take a second and consider what medical issues they currently talk with their clients about. Immunizations? Contraception? Depression Medication (are they taking it?). Breastfeeding? If they think about it, there are a number of things like this that home visitors talk to mothers about.

Where it can get complicated:

- Some religions/cultures believe that pregnancy begins at conception (when the sperm fertilizes the egg)
- Science marks the beginning of pregnancy at the time of implantation (when the fertilized egg is implanted into the womb)
- But just like with immunizations or breastfeeding, we don't decide what the mother is going to do—we simply educate her about options so that she is able to make her own informed decisions.

The next two slides address the common myths about EC.

Additional Information About EC

- This medication does **not cause miscarriage.**
- It will **not hurt a pregnancy** if you are already pregnant.
- It only helps to prevent pregnancy if you have had **recent unprotected sex.**

Visit ec.princeton.edu for additional information and resources.

98

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Notes to Trainer: The website noted on the slide is an important resource to review before the training. You can also refer back to the video vignette, where many of these "myth-busters" were mentioned.

How might this safety card enhance client care?

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Notes to Trainer: Please explain that we will learn about how to use the safety card to do universal education with clients in the next module. For right now, we are just reviewing the information.

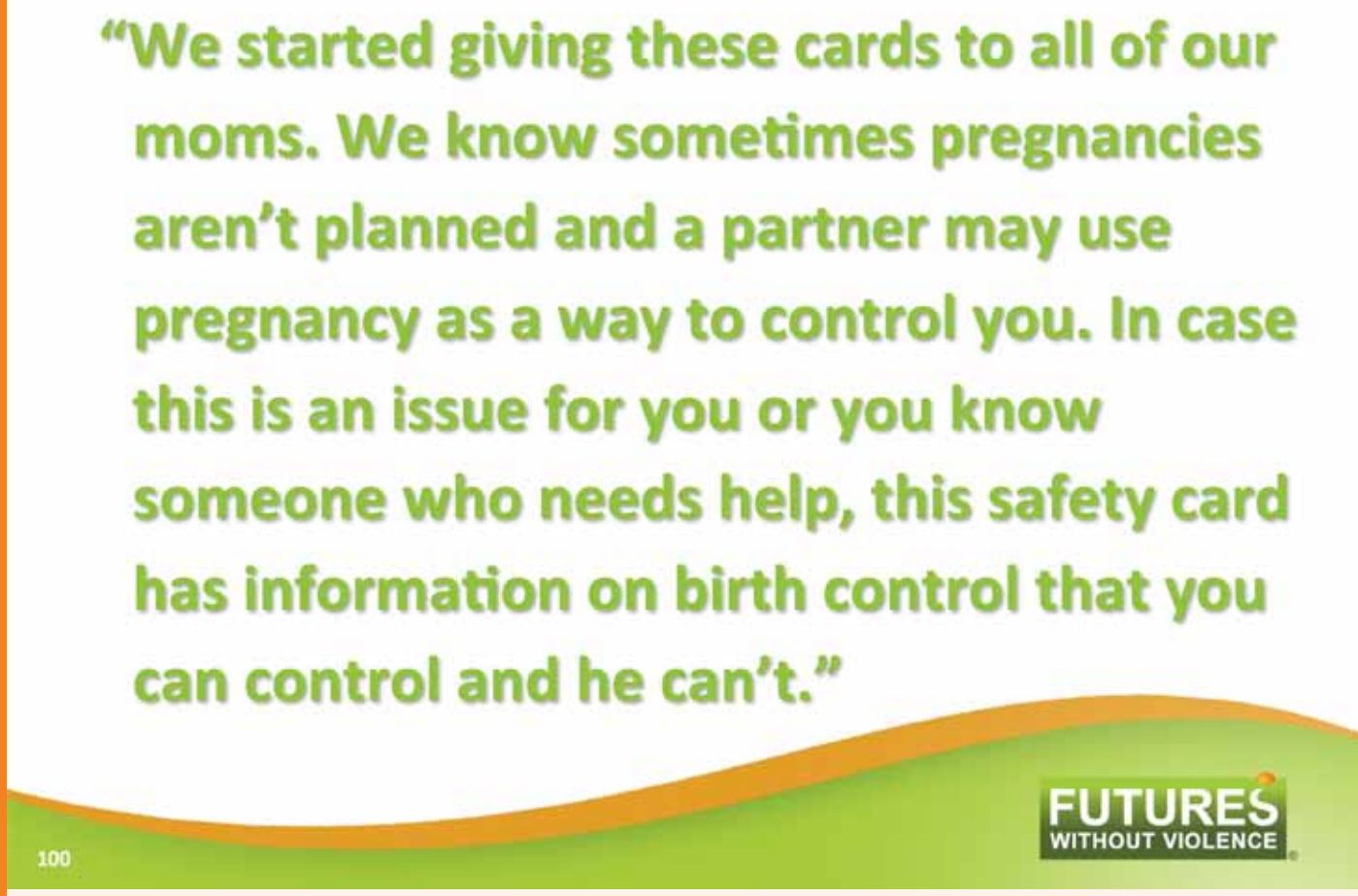
Safety first! Never leave this card for the client without going over it with her—it may put her at risk if her partner accidently finds it. After reviewing the card ask your client if it is safe for them to take the card.

Make sure all participants have the *"Did You Know Your Relationship Affects Your Health?"* safety card (see Appendix E). Ask participants to take the card out, open it up, and follow along as you review the content on the next few slides.

This card focuses on an intervention for reproductive coercion with sexually active women. These are the goals of the safety card intervention:

- Educate clients about IPV, reproductive and sexual coercion.
- Help victims of IPV and RC learn about safety planning, harm reduction strategies and support services.
- Plant seeds for those who are experiencing abuse but not yet ready to disclose.
- Provide primary prevention for clients who have not been in this kind of relationship so they can identify signs of an unhealthy relationship and ideally avoid them.
- Educate clients about what they can do if they have a friend or family member who may be struggling with abuse.

Emphasize that the goal is NOT disclosure or the patient leaving the relationship, but rather enhancing young people's understanding about healthy relationships and increasing their safety in their relationships. The safety card intervention has been identified as one of five effective tools in reducing IPV by the US Preventive Services Task Force. For more information, visit the USPSTF website: www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm



Notes to Trainer: We will review how to use the safety cards with clients in the next module, for now it is important to know that you can be the bridge to information your client may never have considered.

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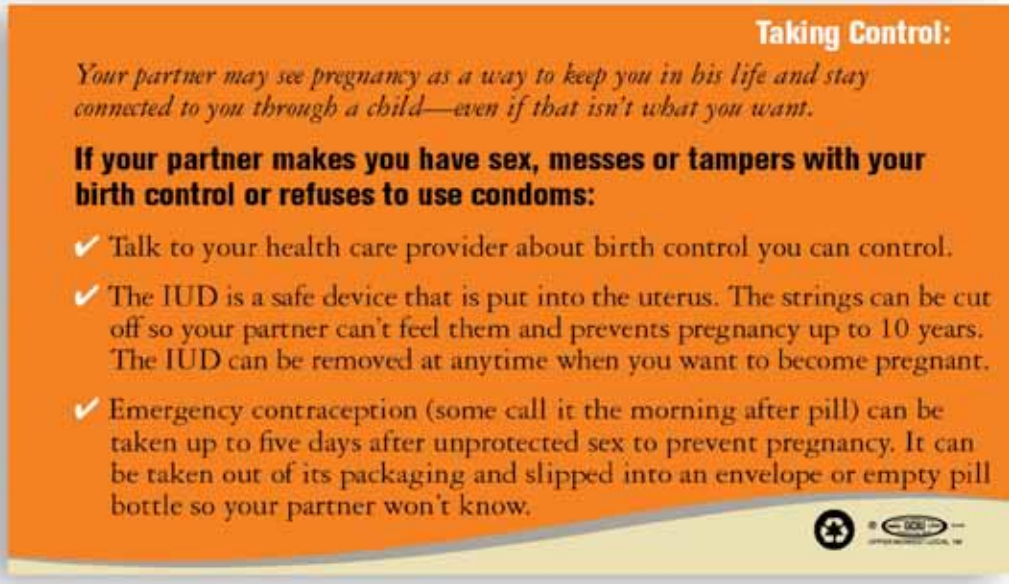
Notes to Trainer: The reproductive health safety card was adapted for American Indian communities in conjunction with Elena Giacci and Native American clinics participating in the *Project Connect* initiative funded by the Office of Women's Health. These are available at www.futureswithoutviolence.org. This card covers information about reproductive and sexual coercion.

Develop partnerships with local family planning organizations



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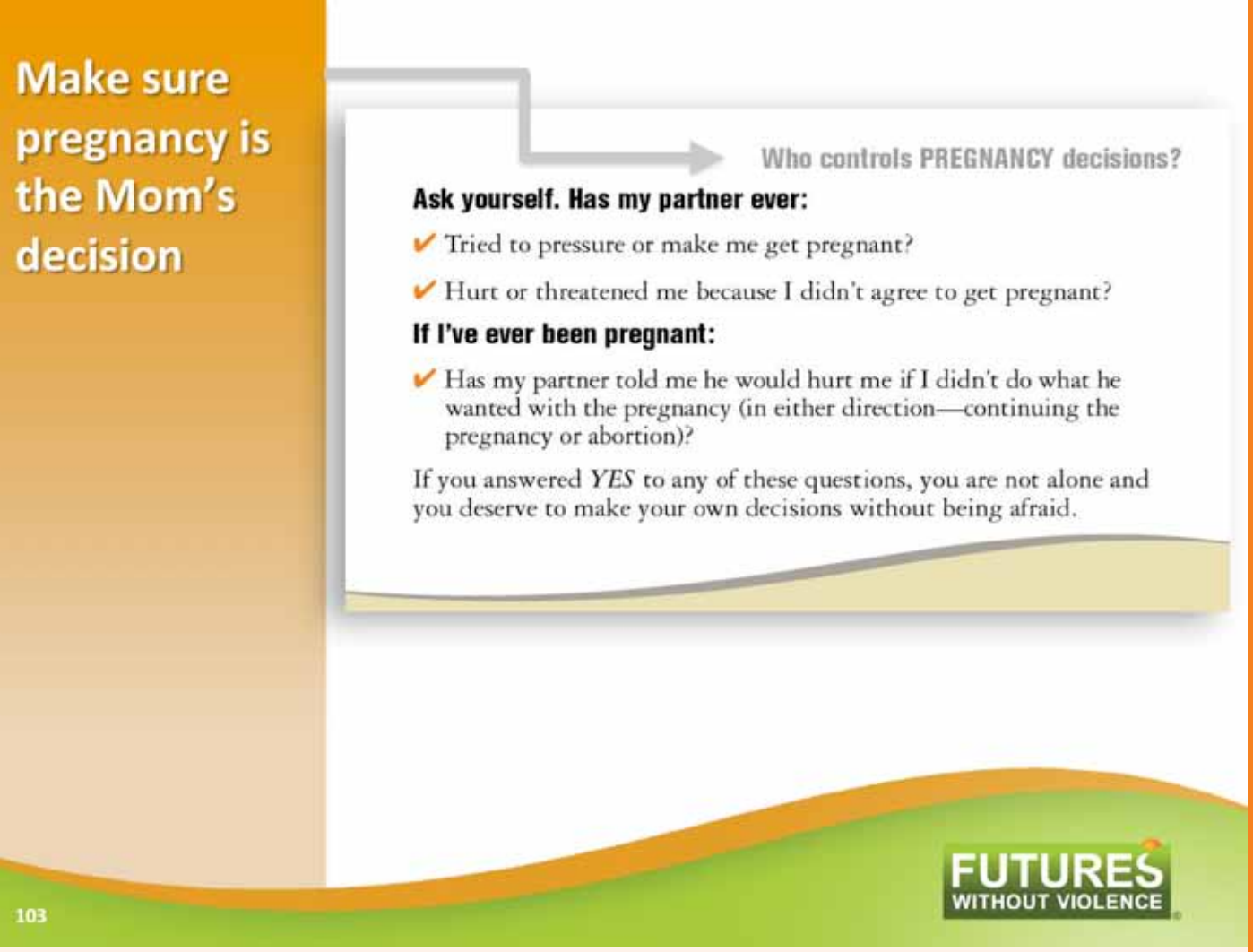
Notes to Trainer: Partnerships with local family planning clinics can help prevent unwanted rapid repeat pregnancies.



Notes to Trainer: Ask the audience: do you think this is an important question to ask Moms? Who controls or decides pregnancy decisions in your relationship?

Question:

How does an intervention for reproductive coercion differ from an intervention for DV?

104

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Notes to Trainer: Read the question aloud to participants.

The Answer:

- When it comes to reproductive coercion, the health care provider is now key to intervention.
- This is done by offering harm reduction strategies for reproductive coercion and providing discreet methods of contraception.

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105

Notes to Trainer: What is the role of home visitation in this arena? Talking about reproductive coercion can open the door to talking about domestic violence and it can give your client a window into a part of her life that she didn't realize she could control.

Among women who received the safety card intervention and experienced recent partner violence:

- 71% reduction in the odds of pregnancy pressure and coercion compared to control group
- 60% more likely to end an unhealthy abusive relationship compared to control

(Miller et al, 2011)

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Notes to Trainer: This study examined the efficacy of a family-planning-clinic-based intervention to address intimate partner violence (IPV) and reproductive coercion. Four free-standing urban family planning clinics in Northern California were randomized to intervention (trained family planning counselors) or standard of care. English-speaking and Spanish-speaking females ages 16-29 years (N = 906) completed audio computer-assisted surveys prior to a clinic visit and 12-24 weeks later (75% retention rate). Analyses included assessment of: intervention effects on recent IPV victims, awareness of IPV services, and reproductive coercion.

RESULTS: Among women reporting past-3-months IPV at baseline, there was a 71% reduction in the odds of pregnancy coercion among participants in intervention clinics compared to participants in the control clinics that provided the standard of care. Women in the intervention arm were more likely to report ending a relationship because the relationship was unhealthy or because they felt unsafe regardless of IPV status (adjusted odds ratio = 1.63; 95% confidence interval=1.01-2.63).

CONCLUSIONS: Results of this pilot study suggest that this intervention may reduce the risk for reproductive coercion from abusive male partners among family planning clients and support such women to leave unsafe relationships. This contributes to the evidence base for using a safety card-based intervention.

Miller E, Decker MR, McCauley H, Tancredi DJ, Levenson R, Waldman J, Schoenwald P, Silverman JG. (2011). A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion. *Contraception.* 83: 274-80.

Mindful Movement

- Stand up
- Breathe in, palms up, arms out stretched
- Breathe out, touch your shoulders with your fingertips
- Breathe in, open and extend your arms out to the sides
- Breathe out as you bring fingertips back to your shoulders

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Module 3: Assessment and Safety Planning for Domestic Violence in Home Visitation

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Module 3

Assessment and Safety Planning for Domestic Violence in Home Visitation

Estimated Module Time: 3 hours

Training Outline

- Learning objectives
- Group discussion exercise
- Scripted assessment
- Using the Healthy Moms, Happy Babies Safety Card (see Appendix F)
- Using the Relationship Assessment Tool (see Appendix G)
- Partnering with local domestic violence programs and advocates
- Safety planning characteristics and defining success
- Resources

Overview

Many home visitation programs struggle with domestic violence screening, referral and with building partnerships with local domestic violence programs. Assessment strategies and tools have been developed to integrate screening for domestic violence more comfortably into home visitation programs. The new federal benchmarks for home visitation require that programs document screening, and track referrals. This module will train home visitors on how to screen, refer and document these activities as part of routine programming.

Learning Objectives

After this training, participants will be better able to:

1. Identify two barriers to home visitors doing domestic violence assessment with clients.
2. Describe why universal education using the HMHB safety card is important for helping clients experiencing domestic violence.
3. Describe why the "Relationship Assessment Tool" is a good screening tool for domestic violence.
4. List action steps in a safety plan that a client can take if she feels unsafe.
5. Explain how developing a Memorandum of Understanding (MOU) with your domestic violence agency can enhance home visitation services.

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Notes to Trainer: Read the objectives aloud.

How comfortable are you with a positive disclosure of domestic violence?

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Estimated Activity Time: 2-3 minutes

Notes to Trainer: Ask participants to follow the directions below. Advise them that they do not have to share what they draw/write.

1) Take out a sheet of paper and draw a line with the words "not at all comfortable" on the far left side of their line and the words "very comfortable" on the far right side of their line.
2) Ask participants to take a minute to think about their comfort level right now with talking to clients about domestic violence—and if he or she feels comfortable asking questions and getting a "yes" as the answer.
3) Discuss how the goal at the end of today's session is that each person has personally moved that needle toward the 'comfortable' end of the scale.
4) Advise participants that this exercise will be repeated at the end of today's session and that you will ask them to consider whether the needle moved as a result of the training, where it moved, and their thinking about this in the context of what they have learned.
5) The exercise is followed by small group discussion (see next slide) to help participants identify and share why it is important for home visitors to know about domestic and sexual violence.

The **"Where Am I?"** exercise is followed by small group discussion (see next slide) to help participants identify and share why it is important for home visitors to know about domestic and sexual violence.

Barriers to Identifying and Addressing Domestic Violence

Home visitors identified the following barriers during the implementation phase of a perinatal home visitation program to reduce domestic violence (DV):

- Comfort levels with initiating conversations with clients about DV
- Feelings of frustration and stress when working with clients experiencing DV.
- Concerns about personal safety when working in homes where DV may escalate.

(Eddy et al, 2008)

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111

Notes to Trainer: This Train the Trainer curriculum is designed to address the barriers uncovered in this study. These barriers were identified during the implementation of the DOVE project which is described as a promising practice in this chapter. Described as a "Town and Gown" partnership, a university partnered with home visitation programs in several counties. The home visitors who participated in the qualitative study about barriers and facilitators to addressing DV during home visits were a combination of nurses, social workers, and unlicensed home visitors.

Eddy T, Kilburn E, Chang C, Bullock L, Sharps P. (2008) Facilitators and Barriers for Implementing Home Visit Interventions to Address Intimate Partner Violence: Town and Gown Partnerships. *Nursing Clinics of North America.* 43:419-435.

Barriers Continued:

- Home visitors report that they fear that their clients who divulge DV may suffer even more abuse at the hand of their abuser in retaliation for divulging the secret
- Barriers to screening include that talking about DV may cause shame and embarrassment for women experiencing abuse and home visitors worrying that they might lose the woman's and child's participation in the home visiting program that aims to help them.

(Eddy et al, 2008)

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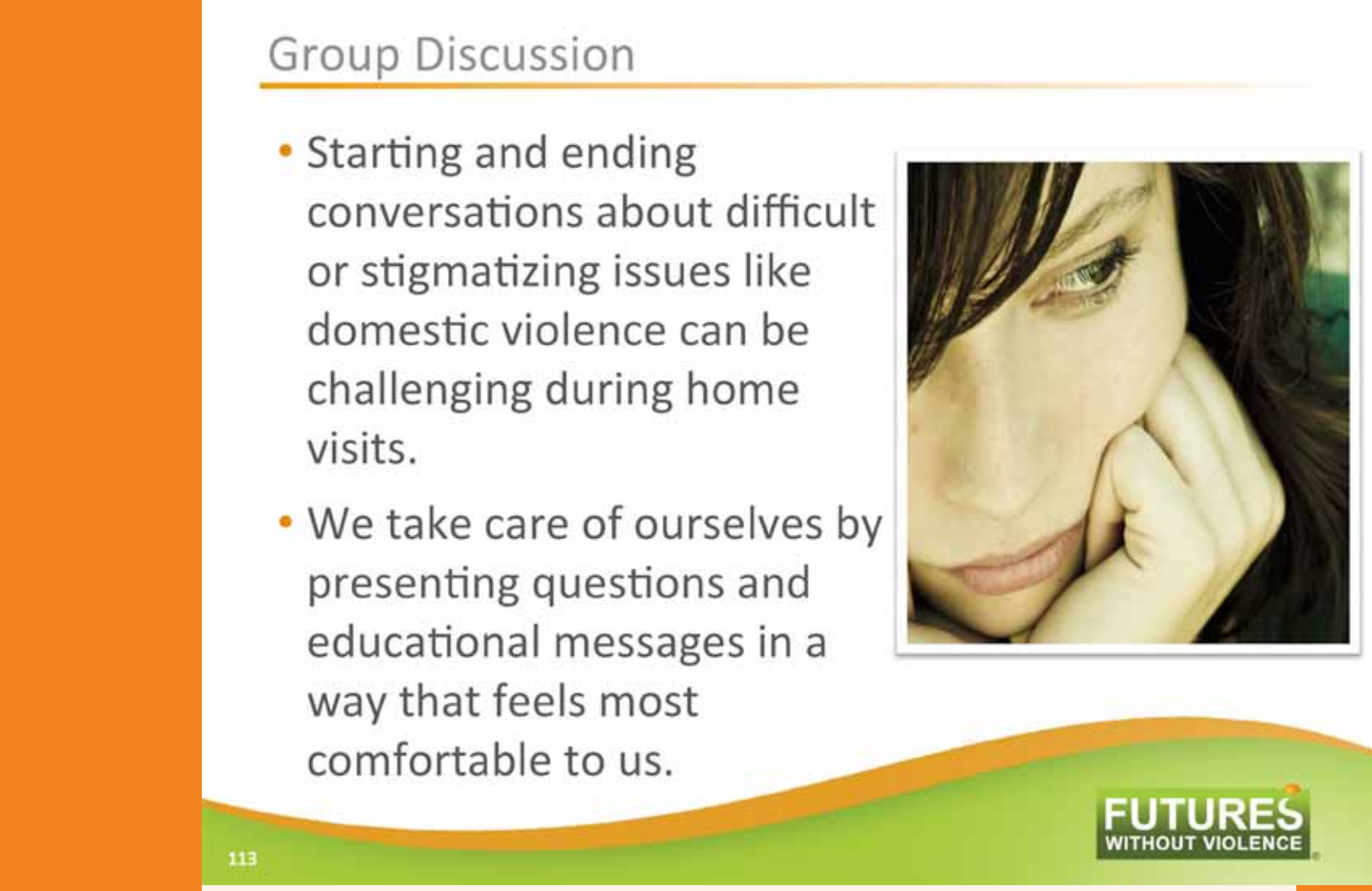
Eddy T, Kilburn E, Chang C, Bullock L, Sharps P. (2008) Facilitators and Barriers for Implementing Home Visit Interventions to Address Intimate Partner Violence: Town and Gown Partnerships. *Nursing Clinics of North America.* 43:419-435.



Estimated Activity Time: 5 minutes

Notes to Trainer: Ask participants to take the first statement and just think about it for a minute. Each person should take a second and ask themselves if this was ever true for you—or true for them or a colleague?

Ask participants, "When doing an assessment with one of your clients and working with standardized forms you have to fill out, have you ever not asked a question the way it was written on the form, or changed the order in which the question appeared?" Ask participants to raise their hands if they think it is a safe environment to share their thoughts. If they are worried about getting into trouble with their supervisor they may remain silent.

Another question to pose to the audience, "Do you think this kind of deviation is a good or bad thing?" Then ask about why participants (hypothetically if need be) might deviate from a form—bringing it back to the statements on the slide.

Tell participants, now let's look at the second statement. Ask them, do you think this is true?

True Domestic Violence Screening Stories

- **"No one is hurting you at home, right?"** (Partner seated next to client as this is asked)—How do you think that felt to the client?
- **"Within the last year has he ever hurt you or hit you?"** (Nurse with back to you at her computer screen)—Tell me about that interaction…
- **"I'm really sorry I have to ask you these questions, it's a requirement of the program."** (Screening tool in hand)—What was the staff communicating to the client?

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Estimated Activity Time: 2 minutes

Notes to Trainer: This can be an interactive or didactic exercise. After reading, ask participants to open their eyes and review statements one by one.

Topics to cover include:

- Do no harm: safety considerations
- When, Where, and How you ask matters
- Screening for IPV should not be a checklist
- If done poorly it can be harmful

One question that often comes up is if you should screen before you have a rapport with the client. The answer is that it depends on the client. If you are working with a homeless mother, you might opt to do this the first time you meet with her as it may be the only time you meet with her.

In this module we will talk about how to do universal education as a gentle opening to screening that might occur in a subsequent visit after you have developed a rapport.

Who do you find most difficult to ask about domestic violence?

How do your assumptions get in the way of this work?

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Estimated Activity Time: 2 minutes

Large group discussion: On the previous slide, the patient was asked **"No one is hurting you at home, right?"** When the nurse was questioned about her screening practice—the nurse said to the patient, "I assumed you weren't one of those people." What do you think that was about? Was she like the nurse? Who do you find most difficult to ask about DV?

SAFETY First

- Never screen for domestic violence in front of a partner, a friend or family member
- Never use a family member to interpret domestic violence education or screening tools
- Never leave domestic violence information around or in a packet of materials without first finding out if it is safe to do so

Notes to Trainer: Often staff tell us there are folks always around when they are supposed to screen for DV. Below are some ideas/strategies you can share with them.

- If you transport the mother in a car somewhere—use that time to educate and screen
- Call mother on the phone and ask if she is alone first, and if so, follow up with education and screening
- Meet mother at her OB appointment or well child check appointment to have a private discussion—typically wait times can be long
- Other ideas?

Relationship Assessment Tool

1. Read the cover sheet about scoring
2. Discussion of scoring
3. Discuss how to change language for same sex partners

Exercise: Think about the most difficult home visitation case you have and answer questions for that client.

a. Score your tool.

b. How many of you scored 20 or higher?

c. How do these questions differ from a question like: "Have you been hit, kicked, slapped by a current/former partner?"


RELATIONSHIP ASSESSMENT TOOL

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Estimated Activity Time: 5 minutes

Notes to Trainer: FUTURES re-titled the Women's Experience of Battering scale (WEB) to *"Relationship Assessment Tool,"* with the permission of the study's author to make it more comfortable for home visitors to share with women.

Tell participants as you pass out copies of the tool, *I would like you to fill this out now thinking about your most recent client who is having a hard time in her relationship. Put on her shoes for a moment. Fill out and score the tool thinking about how she might answer these questions or feel about having a moment to consider these kinds of questions. As a follow up, were there any epiphanies? How many had a score over 20?*

10-item assessment tool that measures women's perceptions about physical danger and power and control in intimate relationships.

- Self-administered or face-to-face interview
- Responses are summed to create score
- 20 points or higher considered high risk of DV
- More sensitive and comprehensive tool for detecting DV compared to tools focusing primarily on physical assault

Sometimes the audience has issues with this tool, how it is scored and how questions are worded. You can let them know this was the best evidence-based tool that covered emotional abuse that was indicative of physical abuse. We look forward to researchers developing even better tools in the future. And yes, we know that a score of 10 on this tool is a negative score. So they might want to bring this up to clients—*I love this tool but the numbering is funny*—don't let that trip you up.

Which Screening Tool is your Program Using?

- Thoughts about the Relationship Assessment Tool and questions asked?
- Could you use this in combination with a screening tool that looked at physical violence only?

Notes to Trainer: Ask participants, why am I asking these questions? Answer: Because states had to make decisions about their choice of screening tools quickly and some may wish they had chosen other tools. We recommend the Relationship Assessment Tool, Appendix G, be used in addition to screening tools that measure physical violence only.

What Is a Mother's Greatest Fear?

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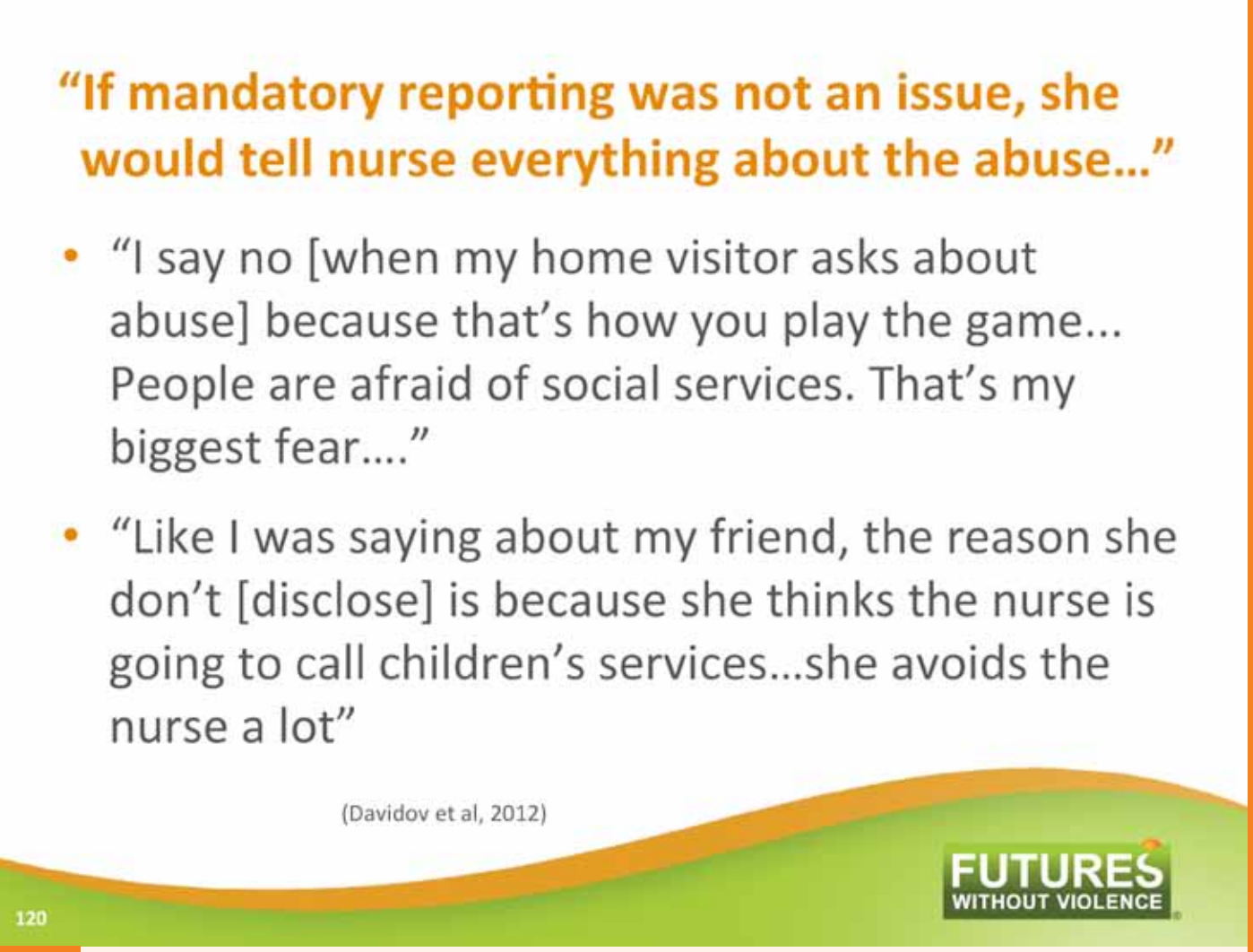
Estimated Activity Time: 3 minutes

Notes to Trainer: Ask participants, what is a mother's greatest fear. Here the answer you are looking for from the audience is child protective service or child welfare taking away children.

Quick conversation with audience: Do you think fear of child welfare involvement affects domestic violence disclosure rates among your clients? Do you think this might affect the federal benchmark results?



Module 3

Notes to Trainer: The mandatory reporting of intimate partner violence (IPV) is a controversial issue that is receiving increased attention. A related concern is whether children's exposure to IPV constitutes child maltreatment, making it reportable to child protective services. These issues have been relatively unexplored within the context of home visitation programs. A secondary analysis of qualitative data collected from community stakeholders, clients, and home visiting nurses in the Nurse-Family Partnership program was carried out. Participants' perceptions about mandatory reporting of IPV and reporting of children's exposure to IPV are highlighted. Emergent themes and implications for research, practice, and policy are discussed.

Davidov MD, Jack Sm, Frost SS, Coben JH. (2012) Mandatory Reporting in the context of home visitation programs: intimate partner violence and children's exposure to intimate partner violence. *Violence Against Women.* 18:595-610

No matter what your state law actually says about whether or not childhood exposure (no direct physical abuse or neglect to child) to domestic violence is reportable, clearly it is an issue either way for moms and maybe even for you.

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Notes to Trainer: FUTURES earlier edition of Healthy Moms, Happy Babies used to have a module on DV being a mandatory report to child welfare. We got rid of it for this reason.

Universal Education and Screening for DV

- To overcome barriers created by mandatory reporting we need to combine universal education with screening for DV
- Starting with universal education followed by face-to-face screening can facilitate conversation

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Group Activity

Take a couple of minutes and read the card carefully.

- How does using the safety card support both staff and clients?
- Pay attention to what stands out for you

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Estimated Activity Time: 2–3 minutes

Notes to Trainer: Hand out the safety card *Healthy Moms, Happy Babies* to the audience. This can be turned into a group discussion, quick debrief or small group activity.

Safety first! Never leave this card for the client without going over it with her—it may put her at risk if her partner accidently finds it. After reviewing the card ask your client if it is safe for her to take the card.

This card was developed with the client's safety in mind and modeled after the 'shoe card' that domestic violence advocates have used for years—making it easier for the client to hide. To turn the card into a staff prompt you would just need to change the wording on the card to make it an assessment tool.

Example from the card: "Do I feel respected, cared for and nurtured by my partner?" Can easily be changed to: "Do you feel respected, cared for and nurtured by your partner?" This works with the other sections of the card as well. Take a minute to think about how you might introduce the card. Debrief ideas with the group.

Quick Activity

- Turn to the person next to you or behind you and give them your card and, in turn, they should give you theirs.
- What happens when you give the card to someone?

Notes to Trainer: What happens is eye contact—connection and a gift that reinforces the message that this issue is important and not just about another check list. The other thing that happens is people smile—you are handing over a picture of a happy baby and a happy mother.

Review Card and Debrief

- What did you notice about the first panel of the card?
- And the second panel?
- What about the size of the card?
- Do you think it matters that it unfolds?
- Why might this card be useful to a survivor of domestic violence?

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Notes to Trainer: Panels one and two are all things folks can relate to on both good days and bad days—it's also important to note that the card begins with what someone deserves—with the positive rather than the negative—it's an important way to begin the conversation.

Safety Precaution: You can tape your business card over hotline numbers and then it just looks like a 'mommy baby thing'. The size of the card matters because you can easily hide it (in a shoe or behind a phone in a smart phone case).

The folding and unfolding of the card gives the learner a socially acceptable way to avoid eye contact with the provider while still listening (important with teens).

Maine Families Home Visitors' Experiences Using the Safety Card

"I think it normalized the conversation and opened up our definition of DV and unhealthy behaviors within relationships. Practice makes it easier to have the conversation and this training bridged our collaboration with our DV partners and encouraged us to know our colleagues."

(Health e-bulletin summer, 2014)

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126

Module 3

National Health Resource Center on Domestic Violence, Health e-bulletin summer 2014, p 16. Available at: www.futureswithoutviolence.org/userfiles/FWV_eBulletin_2014_R3_071720142.pdf

Maine Families Home Visitors' Experiences using the safety card

"The Home Visitors at our site have always done a great job at talking to families about violence in the home. However, they now feel they have a tool (the cards) that actually enhances these conversations and elicits more information than the standard questions being asked about hitting, punching, choking... We have found that many women say "no" to this, however when they read some of the questions on the HMHB (Healthy Moms, Happy Babies) cards, it has brought out some pretty significant disclosures of powerlessness, emotional abuse, and control by their partner."

(Health e-bulletin summer, 2014)

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127

National Health Resource Center on Domestic Violence, Health e-bulletin summer 2014, p 16. Available at: www.futureswithoutviolence.org/userfiles/FWV_eBulletin_2014_R3_071720142.pdf

Sample Script: Safety Card Segue into Screening Tool

- "We have started giving two cards to all our clients for two reasons—in case it might ever be useful for you and so you know how to help a friend or family member if it is an issue for them."
- "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 hotlines on the back and gives simple steps to take to be safer." (Go over panels generally)
- "We also go over this screening tool with our moms—just so we can get a better sense of how it is going in their relationships."

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Notes to Trainer: Tell participants, *if you do nothing but this, it is the definition of success.* Think about it. We provide education about what women deserve in a relationship, we discuss safety planning and where they can get help, and whether or not they are ready to disclose; they have all the tools available to them at hand.

Why Does This Matter?

"Most social support studies have emphasized one-way support, getting love, getting help. . . . The power of social support is more about mutuality than about getting for self. . . . That is, there is a need to give, to matter, to make a difference; we find meaning in contributing to the well-being of others" (Jordan, 2006)

Helping mothers connect to family and friends should include providing opportunities for mothers to give help as well as receive help, "which lessens feelings of indebtedness"

(Gay, 2005)

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Adapted from The Strengthening Families Approach and Protective Factors Framework: Branching Out and Reaching Deeper by Charlyn Harper Browne, PhD September 2014

Jordan, J. V. (2006b). Relational resilience in girls. In S. Goldstein & R. B. Brooks (Eds.), *Handbook of resilience in children.* (pp. 79-90). New York, NY: Springer.

Gay, K. D. (2005, September/October). The Circle of Parents® Program: Increasing social support for parents and caregivers. *North Carolina Medical Journal.* 66(5), 386-388.

You might be the first person who ever talked with her about what she deserves in a relationship.

How is it Going?

All moms deserve healthy relationships. Ask yourself:

- ✔ Do I feel respected, cared for and nurtured by my partner?
- ✔ Does my partner give me space to be with friends or family (or to take breaks from the baby)?
- ✔ Does my partner support my decisions about if or when I want to have more children?

If you answered *YES* to any of these questions, it is likely that you are in a healthy relationship. Studies show that this kind of relationship leads to better health, longer life, and better outcomes for children.

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2. Have a Conversation about DV

You might be the first one to talk with her about what she doesn't deserve in her relationship.

On Bad Days?

Is my relationship unsafe or disrespectful? Ask yourself:

- ✔ Does my partner shame or humiliate me?
- ✔ Does my partner threaten me, hurt me, or make me feel afraid?
- ✔ Does my partner make me do sexual things I don't want to do?

If you answered *YES* to any of these questions, you don't deserve to be hurt and your health care provider can support you and connect you to helpful programs.

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Small Group Activity:

- Get into groups of three: An observer, client and home visitor
- Home visitors: Introduce and hand the card to the client. Practice using the script and your own words.
- Client/Observer: Make Notes of what you liked and how the card helped.

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Estimated Activity Time: 3 minutes

Notes to Trainer: Ask audience to follow the directions and then debrief about how it went.

Safety Card Adaptations for Indian Country and Alaska Natives

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Notes to Trainer: Adapted versions of Healthy Moms, Happy Babies cards for Alaska Native and American Indian communities.

Steps to Safety Card Intervention

1. **Universal Education** - Normalize activity: *"I've started giving this card to all of my clients"*
2. **Educate about DV** - Open the card and do a quick review: *"It talks about healthy and safe relationships...and how relationships affect your health"*
3. **Make the Connection** - Create a sense of empowerment: *"We give this to everyone so they know how to get help for themselves if they were to need it and so they can help a friend or family member..."*
4. **Safety Planning**
5. **Hotline Referral**

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Notes to Trainer: Here are the 5 steps you need to know for a safety card intervention, including how to provide universal education about safety planning and referral sections of the card.

Thoughts on this next video:

- It is idealized
- Ignore the lack of chaos
- Please listen to the words and think about how you might do these things in sequence if things are busy in a family
- Or what activity you could do with a child while a mother does the Relationship Assessment Tool

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Amber

The following video clip demonstrates how to provide universal education using a safety card as a segue into screening for domestic violence.

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Estimated Activity Time: 3 minutes to watch video and 2 minutes for discussion

1) What do you think about the way the home visitor began the visit with the mom?
2) How do you think the presentation of the Healthy Moms, Happy Babies card went? Did it feel judgmental or supportive to you? *Note: The goal with this question is to get the audience to think about the way the card was introduced and how the home visitor suggests the card can be used for a friend or a family member.*
3) Any final thoughts about what you saw? Doable? Concerns?

What we have learned about our intervention:

- Always give two cards
- Use a framework about helping others—this allows clients to learn about risk and support without disclosure
- Having the information on the card is empowering for them—and for the women they connect with

137

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Notes to Trainer: Reminder—using this framework helps to create a sense of empowerment and normalizes the activity with the client. *"We have started giving this out to all our clients in case they need this information for themselves or to help a friend. It talks about safe and healthy relationships…"*

Using the Safety Card as a Segue to Introduce Screening Tools

- Pair up: Client & Home Visitor
- Practice using the safety card to transition into assessment (revisit slide on script for safety card if needed—and we don't need the RAT scored, we are just practicing the segue from the card to the tool).

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138

Module 3

Estimated Activity Time: 3 minutes

Notes to Trainer: For this exercise the audience is reviewing the card as a segue to the Relationship Assessment tool, Appendix G, (see next slide for sample prompt).

Sample Script: Safety Card Segue into Screening Tool

- "We have started giving two cards to all our clients for two reasons—in case it might ever be useful for you and so you know how to help a friend or family member if it is an issue for them."
- "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 hotlines on the back and gives simple steps to take to be safer." (Go over panels generally)
- "We also go over this screening tool with our moms—just so we can get a better sense of how it is going in their relationships."

FUTURES WITHOUT VIOLENCE

Notes to Trainer: Tell participants, *if you do nothing but this, it is the definition of success.* Think about it. We provide education about what women deserve in a relationship, we discuss safety planning and where they can get help, and whether or not they are ready to disclose; they have all the tools available to them at hand.

What Should Be Done if Domestic Violence is Identified or Suspected?

Notes to Trainer: Do a quick call and response with the audience. We are hoping that all home visitors will support the client with unconditional positive regard. Make sure that the following points are covered.

The initial response by you is important.

- Thank client for sharing
- Convey empathy for the client who has experienced fear, anxiety, and shame. “No one deserves this…”
- Validate that DV is a health issue that you can help with
- And let her know you will support her unconditionally without judgment

When Domestic Violence is Disclosed: Provide a 'Warm' Referral and Safety Planning

- "If you are comfortable with this idea I would like to call my colleague at the local program (fill in person's or program's name), she is really an expert in what to do next and she can talk with you about supports for you and your children from her program."
- "I want to go over this section of the safety card I gave you before, if you ever need to get out of the house quickly it is so helpful to have planned out what you will do and this can help remind you about your next steps."

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Notes to Trainer: Getting to know your local DV program staff will help ensure that each referral feels genuine and supportive to your clients.

Small Group Exercise: Safety Planning

- We want every client to do safety planning with a DV advocate, however we know this is not always possible (too rural, etc.)
- Therefore it is important for you to be familiar with the more comprehensive safety plan advocates use
- Please read through the sample safety plan
- Why might something this detailed be helpful?
- Why would it be useful to do with a home visitor or other advocate?

SAFETY PLAN AND INSTRUCTIONS

SAFETY PLAN

Step 1:

Safety during a violent incident. I can use some or all of the following strategies:

A) If I have/decide to leave my home, I will go _____.

B) I can tell _____ (neighbor) about the violence and request they call the police if they hear suspicious noises coming from my house.

C) I can teach my children how to use the telephone to contact the police.

D) I will use _____ as my code word so someone can call for help.

E) I can keep my purse/car keys ready at (place) _____ in order to leave quickly.

F) I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I've am out of danger.

Step 2:

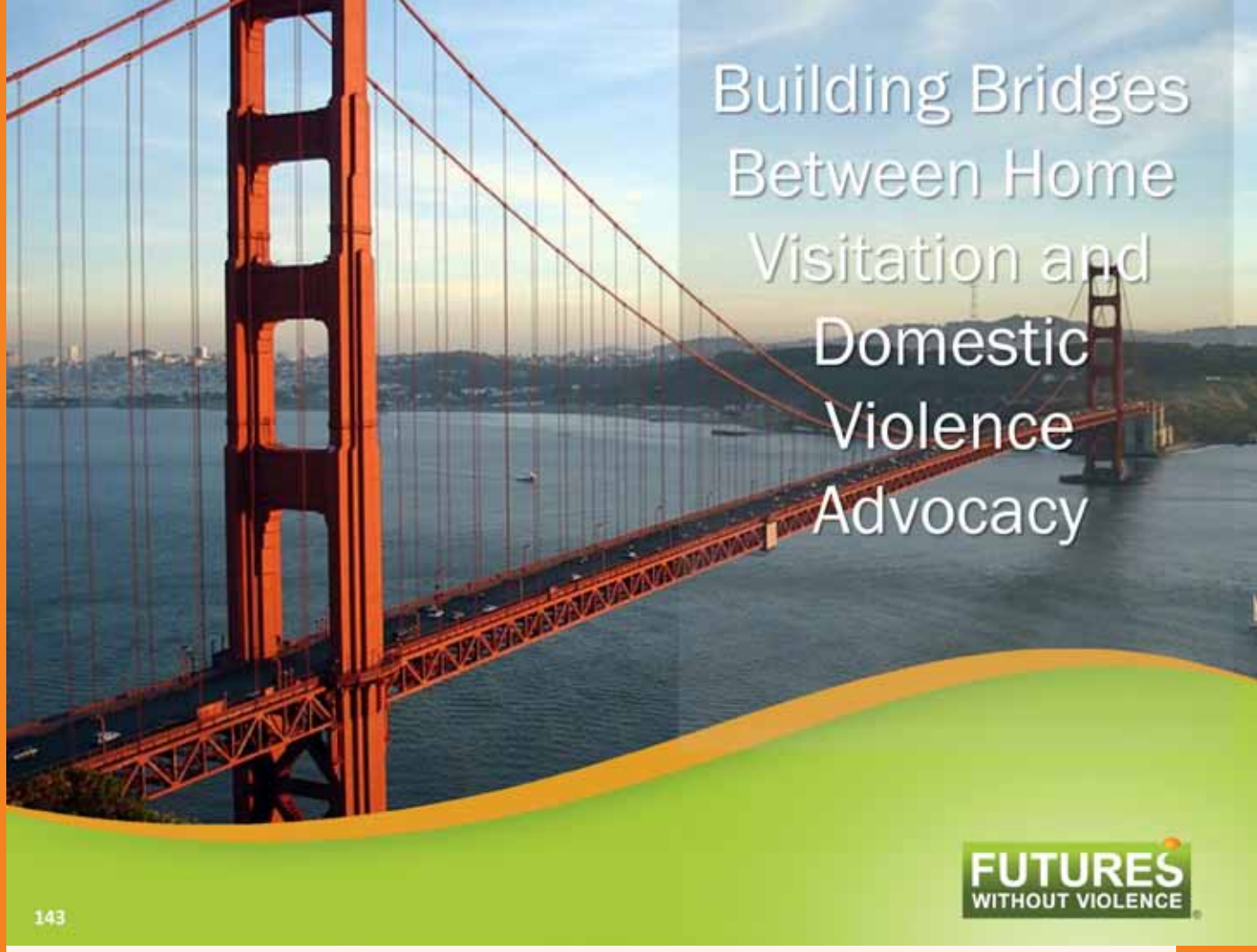
Safety when preparing to leave. I can use some or all of the following safety strategies:

A) I will keep copies of important documents, keys, clothes and money at _____.

B) I will open a savings account by _____, to increase my independence.

Notes to Trainer: Ask the small group to each fill out a section of the plan as if they were a client in a violent relationship—why might this plan be useful? Ask them to share insights into their thinking.

Resource: Safety Plan and Instructions, Appendix H.



Notes to Trainer: Prior to assessment for abuse and violence, practitioners should ensure protocols are in place for a safe and effective response. This means having specified roles and responsibilities within the home visitation setting, knowledge of existing violence prevention and intervention resources within the local community and an established system for activating these resources depending on the situation. Home visitors should not feel that they must have "all the answers." In these moments, having a team in place to call upon is necessary so the provider is not left carrying the weight of the situation alone. It is ideal to have an in-person introduction to an advocate or social worker to connect the client with ongoing support.

Home Visitors do not have to be DV experts to recognize and help clients experiencing domestic violence.

- You have a unique opportunity for education, early identification and intervention.

- And to partner with DV agencies to support your work.

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The Role of the Domestic Violence Agencies and Advocates

- So much more than just shelter services
- They provide training and community supports
- Beyond safety planning, advocates can help clients connect to additional services like:
  - Housing
  - Legal advocacy
  - Support groups/counseling

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145

Notes to Trainer: Contact the nearest domestic violence shelter or the domestic violence coalition in your state to talk with domestic violence advocates and learn more about safety planning, training, and resources for families who have experienced violence in a relationship.

MOU: Partnering with Local Domestic Violence Agencies

The following video clip demonstrates the importance of developing an MOU between home visitation and domestic violence programs.

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Estimated Activity Time: 4 minutes to watch video and 5 minutes for discussion

Small Group Discussion

- What did you think of the video?
- Does your program currently have an MOU with a local DV agency?
- If no, what do you think the barriers are?
- If yes, how is it working ?

147

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Notes to Trainer: Please hand out sample Memorandum of Understanding (MOU), Appendix I.

Lessons Learned from the DV Benchmark

Surprisingly, many women told her that they did not know about local or national resources from which they could get help. They said the only people they were likely to tell about a violent relationship were their friends or family members, who were not always supportive.

(Health e-bulletin, 2014)

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Notes to Trainer: This is a great example of why it so important to give all mother's a HMHB card when it is safe to do so.

National Health Resource Center on Domestic Violence, Health e-bulletin summer 2014, p 5. Available at: www.futureswithoutviolence.org/userfiles/FWV_eBulletin_2014_R3_071720142.pdf

At your table:

- One person in your group calls the national DV hotline (if you speak another language, please ask for information in that language) and tell them you are a home visitor and you want to understand what would happen if you referred a client.
- What would they do if she asked for a local referral?

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Estimated Activity Time: 15 minutes

Notes to Trainer: Ask participants to have one person in their group call the national domestic violence hotline. Tell them to let the hotline staffer know that he/she is a home visitor and would like to understand what would happen if he/she were to refer a client. If caller speaks another language, ask for information in that language. When possible break up the group into 8-10 people and use speaker phone (some in hallway, various corners of the room etc).

Ask participants:

- What was the call like?
- Did you call in another language? How long did it take to get a speaker on the line?
- Did they tell you their services were confidential and anonymous?
- Did it feel like you were talking to a crisis hotline or more like you were talking to a cell phone advocate?

Notes to Trainer: Read the recap of what we've learned aloud.

How comfortable are you with a positive disclosure of domestic violence?

Estimated Activity Time: 2-3 minutes

Ask participants to follow the directions below. Advise them that they do not have to share what they draw/write.

Ask participants to take a minute to think about their comfort level right now with talking to clients about domestic violence—as compared to the first time we asked this question. Do they feel more comfortable asking questions and getting a "yes" as the answer?

Two Person Debrief: Care, Share and "Ah Ha"!

- Think about today's training
- What stands out for you?
- What do you need more of?
- What changed in your thinking?

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152

Module 3

Notes to Trainer: Spend at least 2-3 minutes on debriefing and ask if folks want to share with the group.

Mindful Movement

- Wrap your arms around yourself—left hand over right arm and rub your arm
- Switch arms
- Stretch arms in the air, wiggle fingers, shake hands
- Come back to center

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Thank you

Notes to Trainer: This is where you make the curriculum your own. Add in a favorite quote, favorite thought of the day and thank them for **EVERYTHING** they do to help Moms and kids.

Please complete the Post-Training Survey

155

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Notes to Trainer: Hand-out the post-training survey for participants to complete and provide your contact information for any questions and follow-up. Remind participants that their responses are confidential. Share your closing thoughts and thank participants for their time, expertise, and dedication to making a difference for the families and communities they work with.

Post-training Assessment for Home Visitors, Appendix J.

Appendices

PRE-TRAINING ASSESSMENT FOR HOME VISITORS

Thank you very much for joining us today!

We would like to ask you a few questions about your experiences as a home visitor talking with your clients about healthy relationships and domestic violence in the home. We would like to know what type of training and resources will support you in this work.

Please take a few moments to answer the following questions. Your responses are confidential. We will ask you to complete another survey at the end of the training.

Thank you for your time and expertise to help us better understand how to support home visitors in reducing the effects of domestic violence.

For the purpose of this assessment, the term *clients* refer to the adult caregivers/parents caring for an infant/child.

Vicarious trauma is defined a change in one's thinking [world view] due to exposure to other people's traumatic stories (David Berceli, 2005).

Please circle one answer for each of the following questions:

1) **I am familiar with how working with clients who are experiencing domestic or sexual violence and/or other trauma can affect me and my co-workers.**

   A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

2) **I know several self-care strategies that can help to prevent the effects of vicarious trauma when working with families experiencing domestic and/or sexual violence.**

   A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

3) **I am familiar with how trauma-informed programming can reduce staff barriers to screening for domestic violence.**

   A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

4) **I know what local & national resources are available to assist my clients if they have experienced domestic violence.**

   A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

5) **I have the skills to help a client who is experiencing domestic violence—I know what to say and do.**

   A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

Pre-Training Assessment for Home Visitors

6) I have the skills to educate clients about reproductive coercion and birth control sabotage.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

7) I am familiar with the evidence-based safety card approach to educate clients about domestic violence and healthy relationships.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

8) I am comfortable talking with my clients about healthy and unhealthy relationships.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

9) I have the knowledge to talk with my clients about birth control that is not dependent on a partner (i.e., emergency contraception, IUD).

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

10) I am confident in my ability to help a client with safety planning when domestic violence is disclosed.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

11) Please circle at least one action item that you intend to do differently following the training today (circle as many as apply):

A. Not enough time

B. It's not my job/ or in my job description

C. Asking doesn't help

D. The partner is present for the visit

E. Worried about upsetting the client

F. Not sure what to say if they disclose an abusive/violent relationship

G. Afraid about what would happen if they told me

H. Not sure how to ask questions without seeming too intrusive

I. Not knowing where to refer them to

J. Worried about mandated reporting to child welfare or child protective services

K. Have already screened them at past visit

L. Does not apply to my client population

M. Other _____

12) Have you ever had training on domestic and sexual violence?

A. Yes

B. No

13) In the past 6 months, how many of your own clients have disclosed to you that they are victims of domestic and/or sexual violence?

A. 75% or higher

B. 50% to 74%

C. 25% to 49%

D. 10% to 24%

E. None

14) As part of your home visits, are there specific protocols about what to do when a client discloses domestic and/or sexual violence?

A. Yes

B. No

C. Not applicable

D. Don't know

15) Does your home visitation program have (circle all that apply)?

A. Reflective supervision

B. Regular debriefing/case conferences about difficult cases

C. Supports for staff exposed to violence

D. Partnership with a local domestic violence agency

E. Brochures, cards or information about domestic and sexual violence

F. Prompts inserted into intake forms to assess for domestic and sexual violence

G. In-service trainings for all staff on domestic and sexual violence

H. Materials on domestic and sexual violence that are specifically targeted to teen parents

I. Other (please be as specific as you can): _____

_____

_____

_____

16) Are educational materials available on domestic and sexual violence in the languages most commonly spoken in your clinic setting?

A. Yes

B. No

C. Not sure

Pre-Training Assessment for Home Visitors

17) Are the materials available on domestic and sexual violence inclusive of diverse relationships including sexual minorities, LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) clients?

A. Yes

B. No

C. Not sure

18) What support do you need to incorporate discussion of domestic and sexual violence in all your home visits? (circle all that apply)

A. Workshops and training sessions

B. Protocols that include specific questions to ask

C. List of violence-related resources and who to call with questions

D. Case consultation

E. On-line training

F. Other (Please specify) _____

_____

_____

_____

19) Please describe one thing that you want to be addressed in the training today that would really help you to work with clients experiencing domestic violence/sexual assault (be as specific as you can): _____

_____

_____

_____

_____

_____

_____

Additional Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your time!

Appendix B

SELF-CARE AND RELATIONSHIPS CHECKLIST

It may be helpful to take an inventory of how often we engage in specific relationship-building practices. Use the checklist below to assess what you already do to stay connected as well as to think about ideas for creating and sustaining relationships.

Using the scale below (1=never, 5=always), identify how frequently you currently do the following things to stay connected to others.

5 = Always 4 = Often 3 = Sometimes 2 = Rarely 1 = Never

Rituals

___ Cook a meal with family/friends.

___ Eat a meal with family/friends.

___ Attend events that are important to your friends/family (e.g., concerts, team games, etc.).

___ Take time to say good morning/good night/ goodbye.

___ Participate in spiritual/religious rituals in community.

___ Celebrate life through rituals and routines with friends/family (special things you do every day).

___ Celebrate birthdays/accomplishments and other ceremonies.

Reflection and Balance

___ Prioritize relationships over work.

___ Evaluate the quality of your current relationships.

___ Let go of those connections that are unhealthy and serve as a barrier to self-care.

___ Laugh with others, whether at work or at home.

___ Be nurturing to others.

___ Accept nurturing from others.

___ Listen.

___ Be open to new ideas from friends/family.

___ Feel proud of yourself and your family/friends.

Activities

___ Spend time relaxing with family/friends (e.g., play games, watch movies, other fun activities).

___ Capture memories with photos.

___ Read fun stories/ books with your family.

___ Keep a family journal.

___ Participate in volunteer activities with friends/family.

___ Take a vacation with friends/family (day trip, mini vacation, and long weekends).

Communication

___ Make time to check in with loved ones to let them know how much you love/care for them (e.g., phone calls, notes, emails, etc.).

___ Give hugs, kisses, and/or other signs of affection.

___ Discuss why relationships with family/ friends matter.

___ Seek family/couples therapy when needed.

___ Ask for help from a friend/family member when needed.

___ Communicate openly and effectively to those who are important to you.

___ Express concerns constructively.

___ Have a “phone date” with a friend/family member you haven’t spoken with in awhile.

ORGANIZATIONAL SELF-CARE CHECKLIST

Evaluating Your Organizational Self-care Practices

After evaluating the stress level of your organization and identifying what you find helpful and not helpful in times of stress, you can begin to think about ways your organization can create a healthier work environment. Such an environment is one that supports individual self-care and creates a sense of team self-care—both of which are important to productivity, service provision, and staff well-being.

The following *Organizational Self-Care Checklist* is designed to provide organizations with new ideas and concrete examples of what it means to promote a culture of self-care. Building an organizational culture of self-care often requires an initial period of difficult reflection on what is currently happening in your organization. The goal is to build self-care practices into daily routines and rituals, so that they become very good habits. Use the *Organizational Self-Care Checklist* to assess what your organization is currently doing to support self-care and get ideas for how to build on these to further create and sustain a culture of self-care.

Instructions: Check off everything your organization currently does to support self-care.

Training and Education

- ☐ The organization provides education to all employees about stress and its impact on health and well-being.
- ☐ The organization provides all employees with education on the signs of burnout, compassion fatigue and/or vicarious traumatization.
- ☐ The organization provides all employees with stress management trainings.
- ☐ The organization provides all employees with training related to their job tasks.
- ☐ Staff are given opportunities to attend refresher trainings and trainings on new topics related to their role.
- ☐ Staff coverage is in place to support training.
- ☐ The organization provides education on the steps necessary to advance in whatever role you are in.
- ☐ Other: _____

Support and Supervision

- ☐ The organization offers an employee assistance program (EAP).
- ☐ Employee job descriptions and responsibilities are clearly defined.
- ☐ All staff members have regular supervision.
- ☐ Part of supervision is used to address job-stress and self-care strategies.
- ☐ Part of supervision is used for on-going assessment of workload and time needed to complete tasks.
- ☐ Staff members are encouraged to understand their own stress reactions and take appropriate steps to develop their own self-care plans.
- ☐ Staff members are welcome to discuss concerns about the organization or their job with administrators without negative consequences (e.g., being treated differently, feeling like their job is in jeopardy or having it impact their role on the team).
- ☐ Staff members are encouraged to tak breaks, including lunch and vacation time.
- ☐ The organization supports peer-to-peer activities such as support groups and mentoring.
- ☐ Other: _____

continued on next page

The Organizational Self-Care Checklist (page 2)

Employee Control and Input

- ☐ The organization provides opportunities for staff to provide input into practices and policies.
- ☐ The organization reviews its policies on a regular basis to identify whether they are helpful or harmful to the health and wellbeing of its employees.
- ☐ The organization provides opportunities for staff members to identify their professional goals.
- ☐ Staff members have formal channels for addressing problems/grievances.
- ☐ Other:_____

Communication

- ☐ Staff members have regularly scheduled team meetings.
- ☐ Topics related to self-care and stress management are addressed in team meetings.
- ☐ Regular discussions of how people and departments are communicating and relaying information are addressed in team meetings.
- ☐ The organization provides opportunities for staff in different roles to share their "day in the life" (see Activity ## for an example).
- ☐ The organization has a way of evaluating staff satisfaction on a regular basis.
- ☐ Other: _____

Work Environment

- ☐ The work environment is well-lit.
- ☐ The work environment is physically well-maintained (e.g., clean, secure, etc.).
- ☐ Information about self-care is posted in places that are visible.
- ☐ Employee rights are posted in places that are visible.
- ☐ The organization provides opportunities for community building among employees.
- ☐ The organization has a no-tolerance policy concerning sexual harassment.
- ☐ The organization has a no-tolerance policy concerning bullying.
- ☐ Workplace issues, including grievance issues and interpersonal difficulties, are managed by those in the appropriate role and remain confidential.
- ☐ Other: _____

Discussion Questions

1) What was this process of filling out the checklist like for you?
2) Were you surprised by any of your responses? If so, which ones?
3) What ideas did you find on the checklist that you liked/did not like?
4) What are the things that you found realistic/not realistic to implement?
5) What are some of the barriers or challenges to implementing these practices?

HOME VISITOR SAFETY PROTOCOL

I. General Safety:

A. If you identify imminent danger to you or to anyone in the house:

i. Leave immediately.
ii. Call 911 or your local emergency number—if anyone is in immediate danger including children.
iii. Call the local DCF Office (XXX) or State Child Abuse Hotline at 1-800-649-5285 if you are a mandated reporter or have a release from the non offending parent and suspect child abuse.
iv. Call your supervisor to advise of the situation.
v. Upon return to the office, debrief with your supervisor or coworker regarding what was observed during the visit.
vi. Contact the family as safety permits (in consultation with your supervisor) to ensure that everyone is safe. Assure the participant that you will continue to work with them (if possible) within program guidelines and safety plan for resuming work together.

B. Overall Safety

i. Immediately prior to a home visit with a family:
   1. Ask again if there are animals there and if so, can they be placed in a bedroom or backyard during the visit.
   2. Confirm that the participating parent and/or any other people are home for the visit prior to leaving the office.
   3. If additional people are at the house or are visiting, determine if you'd rather reschedule the visit.
   4. Schedule to avoid visits after dark; avoid scheduling late afternoon visits on Fridays or before a holiday.
   5. If traveling to an area that is new to the advocate, before the scheduled visit, drive by to become familiar with the area, note road conditions and safety and test cell service.
   6. Be aware of the resources in the area where help could be obtained if an emergency occurs.
   7. Leave make-of-car, license plate number with supervisor and co-workers.
   8. Leave a schedule of visits for the day with the office/coworker/supervisor. Include beginning and ending times for each visit. If major changes are made, inform the office of changes.
   9. Keep vehicle well maintained with at least a half-tank of gas.
   10. If carrying a cellular phone, program the phone so that a call to 911 or other emergency services can easily be made.
   11. Leave valuables at home or place in the trunk of your car before leaving the office. Do not attempt to place valuable items in the trunk while parked for a visit.
   12. Carry in a pocket your driver's license and a small amount of cash.
   13. Wear comfortable clothing and shoes.

ii. When preparing to park and leave your vehicle:
   1. Never park in a driveway, you could get parked in.
   2. Observe the safety of the home/neighborhood before stopping. If there are

questionable activities, continue driving and return to the office. Inform your supervisor immediately.

3. Be alert, do not become pre-occupied. Turn off the radio - look, listen and feel.
4. Park in the open and near a light source that offers the safest walking route to the home.
5. Park on the road/street rather than the driveway and in the direction in which you will leave.
6. When possible, locate the family's building before exiting the car when the family lives in an apartment complex.
7. Take only the items necessary for the home visit. Purses and/or wallets should be left in the car.
8. Do not leave valuables visible in your car.
9. Lock your car at all times.

iii. When approaching the home:

1. When you leave your vehicle, know where you are going. Be aware of your surroundings.
2. If you are approached, be brief with the person and continue moving. Do not be drawn into conversations. Be neither friendly nor rude. Do not make the person angry. Wear a blank but firm expression. If the person continues to talk, say that you are in a hurry right now. If a person persists, follows you, or if you believe that you are in danger, yell for help as loudly as you can. Run to the nearest place where there are people.
3. Observe the outside of the home, surrounding homes, animals and/or unfamiliar vehicles.
4. Be aware of smells associated with substance use.
5. Look and listen for signs of someone at home and assess whether there is any sign of danger involving the occupants of the home.
6. Do not enter the yard/home when:
   a. Questionable persons are present
   b. Parent/others are intoxicated
   c. Violence is in progress
   d. There is no quick escape
   e. Vicious animals are present

iv. When entering the home:

1. Go to the door that is in plain sight of the road/street and stand to the side of the door when knocking.
2. Do not enter the home if an unseen person calls for you to enter.
3. When door is opened, quickly observe inside to determine if there are any threats to your safety.
4. Do not enter the home if an adult is not present. If the parent or caregiver with whom you normally work is unexpectedly not at home and the child is staying with someone who is a stranger to you, indicate that you will contact the parent/caregiver to reschedule for another time.
5. Leave the residence if you feel unsafe entering the home.

v. When in the home:

1. Stay near an exit. Remain alert and observant.

2. Pay attention to unusual smells, particularly those associated with the manufacture or use of drugs.
3. Remain aware of the possibility of other persons in the home and inquire about anyone who appears to be in another room.
4. Limit the amount of personal information shared with families.
5. Do not go into any other parts of the home without the parent's permission. Proceed with caution when entering any room.
6. When accepting food or beverages, use common sense; bring snacks to share; bring your own water bottle.
7. When there is a choice, sit in a hard chair rather than upholstered furniture.
8. Leave immediately if you feel unsafe, encounter harassing behavior or a threat of violence, observe signs of substance abuse or if violence occurs. Consult with your supervisor.

vi. When leaving the home:
1. Observe any activity or persons near the home or in the neighborhood.
2. When leaving a home visit have car keys in hand when walking to your car. Do not linger to make phones calls or notes, leave immediately.

v. Safety Materials to have available in your car:
1. Disinfectant wipes and hand cleaner

II. Firearms:

Definition: Open display of firearms and ammunition during a home visit or when a family informs you that they are readily obtainable and/or accessible.

A. Consider the following:

i. If you view firearms, not in a locked case, assume there is an imminent danger to you, the child(ren) and/or other adults in the home, leave immediately.
ii. If not in view, determine their whereabouts.

B. What to do:

i. If there is imminent danger, leave the home and follow the General Safety Guidelines.
ii. If there is no danger, but the family informs you that there is an unlocked firearm and ammunition in the home:
1. Talk to the parents regarding keeping the firearm and ammunition in a locked cabinet.
2. Encourage and demonstrate to parents how to warn children about guns and how to discuss the gun violence they see on television and in the movies.
3. Remind the parents of the need for repetition for children to learn how to keep away from guns.

III. Health:

A. Smoking

i. If you are sensitive to cigarette smoke, plan ahead of time a comfortable strategy for offering to step outside or join the person outside while she smokes.

Home Visitor Safety Protocol

B. Lice/bed bugs

i. When there is a choice, sit in a hard chair rather than upholstered furniture.
ii. Don't bring bags inside the house.

C. Sickness

i. Before a visit, if you are sick or are concerned that a member of the family that you are visiting is sick, determine if it best to reschedule the visit.

D. Allergies

i. Do not accept food or beverages if you have food allergies.
ii. Ask again if there are animals there and if so, can they be placed in a bedroom or backyard during the visit.

IV. Weather:

A. Consider weather when determining the safety of a visit.

i. Before a visit, check the weather forecast the day before your visit and determine road safety accordingly—especially in mud season and winter.
ii. Inform the family as soon as you can if you need to reschedule the visit due to weather.

Thank you to Journeys Home in Vermont for their Safety Protocol Template for home visitors.

EXAMPLE OF THE RELATIONSHIP AFFECTS HEALTH SAFETY CARDS

(ENGLISH AND SPANISH)

Tear out these sample cards and fold them to wallet size. To order additional cards for your program go to: www.FuturesWithoutViolence.org/health.

¿Quién controla las decisiones de EMBARAZO?

Pregúntese. Mi pareja:

- ✔ ¿Ha intentado presionarme o forzame para que me embarace?
- ✔ ¿Me ha lastimado amenazado porque no estoy de acuerdo en embarazarme?

Si alguna vez he estado embarazada:

- ✔ ¿Mi pareja me ha dicho que me lastimaría si no hacía lo que el quería con el embarazo (en cualquier dirección, continuar con el embarazo o aborto)

Si respondió *SÍ* a cualquiera de estas preguntas, no esta sola y merece tomar sus propias decisiones sin tener miedo.

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Obteniendo Ayuda

- ✔ Si su pareja revisa su teléfono celular o textos, hable con su proveedor de atención médica acerca de cómo usar su teléfono para llamar a los servicios de violencia doméstica, para que su pareja no pueda verlo en su registro de llamadas.
- ✔ Si tienen una enfermedad de transmisión sexual (ETS) y teme que su pareja la lastime si le dice, hable con su proveedor de atención médica acerca de cómo estar más segura y como ellos le pueden decir a su pareja de la infección sin usar su nombre.
- ✔ Estudios muestran que educar a sus amigos y familiares sobre el abuso puede ayudarles a tomar pasos para estar más seguros—dándoles esta tarjeta puede hacer una diferencia en sus vidas.

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Fundado en parte por el Departamento de Salud y Servicios Humanos de EE. UU. para la Oficina de la Salud de la Mujer (Subsidio #1 ASTWH110023-01-00) y la Administración de Niños, Jóvenes y Familias (Subsidio #90EV0414).

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Todas estas líneas nacionales pueden conectarla a recursos locales y brindarle apoyo. Para obtener ayuda 24 horas al día, llame al:

Línea Nacional Sobre la Violencia Doméstica
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

Línea Nacional de Maltrato entre Novios Jóvenes
1-866-331-9474
www.loveisrespect.org

Línea de Crisis Nacional de Abuso Sexual
1-800-656-4673
www.rainn.org

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Who controls PREGNANCY decisions?

Ask yourself. Has my partner ever:

- ✔ Tried to pressure or make me get pregnant?
- ✔ Hurt or threatened me because I didn't agree to get pregnant?

If I've ever been pregnant:

- ✔ Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered *YES* to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.

Getting Help

- ✔ If your partner checks your cell phone or texts, talk to your health care provider about using their phone to call domestic violence services—so your partner can't see it on your call log.
- ✔ If you have an STD and are afraid your partner will hurt you if you tell him, talk with your health care provider about how to be safer and how they might tell your partner about the infection without using your name.
- ✔ Studies show educating friends and family about abuse can help them take steps to be safer—giving them this card can make a difference in their lives.

Funded in part by the U.S. Department of Health and Human Services' Office on Women's Health (Grant #1 ASTWH110023-01-00) and Administration on Children, Youth and Families (Grant #90EV0414).

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org

¿Está en una relación SANA?

Pregúntese:

- ✔ ¿Es mi pareja bueno conmigo y respetuoso de mis preferencias?
- ✔ ¿Apoya mi pareja mi uso de anticonceptivos?
- ✔ ¿Apoya mi pareja mis decisiones sobre si quiero y cuando quiero tener más hijos?

Si respondió *SÍ* a estas preguntas, es probable que está en una relación sana. *Estudios muestran que este tipo de relación conduce a una mejor salud, una vida más larga, y ayuda a sus hijos.*

Are you in a HEALTHY relationship?

Ask yourself:

- ✔ Is my partner kind to me and respectful of my choices?
- ✔ Does my partner support my using birth control?
- ✔ Does my partner support my decisions about if or when I want to have more children?

If you answered *YES* to these questions, it is likely that you are in a healthy relationship. *Studies show that this kind of relationship leads to better health, longer life, and helps your children.*

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¿Está en una relación ENFERMIZA?

Pregúntese:

- ✔ ¿Mi pareja se entremete con mi anticonceptivo o trata de que quede embarazada cuando no yo quiero estar?
- ✔ ¿Mi pareja se niega a usar condones cuando se lo pido?
- ✔ ¿Mi pareja me hace tener relaciones sexuales cuando no quiero?
- ✔ ¿Mi pareja me dice con quién puedo hablar o dónde puedo ir?

Si respondió *SÍ* a cualquiera de estas preguntas, su salud y seguridad puede estar en peligro.

Are you in an UNHEALTHY relationship?

Ask yourself:

- ✔ Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- ✔ Does my partner refuse to use condoms when I ask?
- ✔ Does my partner make me have sex when I don't want to?
- ✔ Does my partner tell me who I can talk to or where I can go?

If you answered *YES* to any of these questions, your health and safety may be in danger.

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¿Está siendo afectado la su CUERPO?

Pregúntese:

- ✔ ¿Tengo miedo pedirle a mi pareja que use condones?
- ✔ ¿Tengo miedo que mi pareja me lastime si le digo que tengo una infección de transmisión sexual (ITS) y el necesita tratamiento?
- ✔ ¿He escondido los anticonceptivos de mi pareja para que no me embarace?
- ✔ ¿Mi pareja me ha lastimado físicamente o le he tenido miedo?

Si respondió *SÍ* a cualquiera de estas preguntas, puede estar en riesgo de ITS/VIH, embarazos no deseados, y lesiones graves.

Is your BODY being affected?

Ask yourself:

- ✔ Am I afraid to ask my partner to use condoms?
- ✔ Am I afraid my partner would hurt me if I told him I had an STD and he needed to be treated too?
- ✔ Have I hidden birth control from my partner so he wouldn't get me pregnant?
- ✔ Has my partner made me afraid or physically hurt me?

If you answered *YES* to any of these questions, you may be at risk for STD/HIV, unwanted pregnancies and serious injury.

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Tomando Control:

Su pareja puede ver el embarazo como una forma de mantenerse en su vida y mantenerse conectado a través de un niño, aun cuando eso no es lo que usted desea.

Si su pareja le hace tener sexo, se entremente o altera su anticonceptivo, o se niega a usar condones:

- ✔ Hable con su proveedor de atención médica sobre anticonceptivos que usted pueda controlar (como el dispostivo intrauterine (DIU), implante anticonceptivo o inyección anticonceptiva).
- ✔ El DIU es un dispositivo de seguro que se pone en el útero y evita un embarazo hasta por 10 años. Los hilos se puden cortar para que su pareja no los sienta.
- ✔ Anticonceptivos de emergencia (unos le llaman la píldora de la mañana siguiente) se puede tomar hasta cinco días después de tener relaciones sexuales sin protección para evitar un embarazo. Se pueden sacar de su paquete y ponerlos en un sobre o botella de píldoras vacía para que su pareja no sepa.

Taking Control:

Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn't what you want.

If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:

- ✔ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).
- ✔ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can't feel them. The IUD can be removed at anytime when you want to become pregnant.
- ✔ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won't know.

EXAMPLE OF THE HEALTHY MOMS, HAPPY BABIES SAFETY CARDS

(ENGLISH AND SPANISH)

Tear out these sample cards and fold them to wallet size. To order additional cards for your program go to: www.FuturesWithoutViolence.org/health.

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Plan de Seguridad

Si su pareja la está lastimando, usted no tiene la culpa. Usted merece estar segura y ser tratada con respeto.

Si su seguridad está en riesgo:

1. Llame al 911 si corre peligro inmediato.
2. Prepare un paquete de emergencia, en caso de que tenga que irse repentinamente, que incluya: dinero, chequera, llaves, medicinas, una muda de ropa, y documentos importantes.
3. Hable con su visitador domiciliario para ayuda con llamadas a líneas de asistencia locales o nacionales, para la atención de la violencia doméstica y para más información sobre planeación de seguridad.

Tomando el Control

Referencias Pueden Ayudar

Buscando apoyo para usted y sus hijos le puede ayudar a avanzar hacia un futuro más saludable—aún el paso más poqueño es algo para celebrar.

Mientras que programas de la violencia doméstica locales y nacionales pueden ayudar con su plan de seguridad y pueden proporcionarle con referencias a refugios seguros, también ofrecen servicios para mujeres que no quieran, o no están listas para irse al refugio. Muchos programas ofrecen:

- grupos de apoyo para mujeres y programas para niños.
- clases para fomentar su confidencia, planear para su futuro, y apoyarle en la crianza de sus hijos—llame a su programa local para averiguar lo que está disponible.

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Líneas directas nacionales pueden conectarle a los recursos locales y proporcionarle apoyo:

Para obtener apoyo gratuito, las 24 horas del día, llame:

Línea Nacional Sobre la Violencia Doméstica
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224

Línea Nacional sobre el Abuso de Novios Adolescentes
1-866-331-9474

Línea Directa para la Atención de Casos de Violencia Sexual
1-800-656-4673

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Mamás Sanas, Hijos Felices

Safety Planning

If you are being hurt by a partner it is not your fault. You deserve to be safe and treated with respect.

If your safety is at risk:

1. Call 911 if you are in immediate danger.
2. Prepare an emergency kit in case you have to leave suddenly with: money, checkbook, keys, medicines, a change of clothes, and important documents.
3. Talk to your home visitor for help calling the local or national domestic violence hotline for additional information on safety planning.

Taking Control Back

Referrals Can Help

Getting support for yourself and your children can help you move toward a healthier future—even the smallest step is something to celebrate.

While local and national domestic violence programs can help with safety planning and provide referrals to safe shelters, they also provide services for women who may not want or be ready to go to shelter. Many programs have:

- drop-in support groups for women and programs for children.
- classes to build confidence, plan for the future and support your parenting—call your local program to find out what is available.

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National hotlines can connect you to your local resources and provide support:

For free help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224

Teen Dating Abuse Hotline
1-866-331-9474

Rape, Abuse, Incest, National Networks (RAINN)
1-800-656-HOPE (1-800-656-4673)

Healthy Moms, Happy Babies

¿Cómo le va?

Toda mamá merece relaciones sanas. Pregúntese:

- ✔ ¿Me siento respetada, cuidada, y apoyada por mi pareja?
- ✔ ¿Mi pareja me da espacio para salir con amigos o familia (o tomar descansos del bebé)?
- ✔ ¿Mi pareja apoya mis decisiones sobre cuándo o si quiero tener más hijos?

Si usted contestó SÍ a algunas de estas preguntas, es probable que usted está en una relación sana. Los estudios muestran que este tipo de relación lleva a una vida más saludable y larga, y mejores resultados para sus hijos.

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¿Qué tal los días malos?

¿Estoy en una relación que no es segura o respetuosa? Pregúntese:

- ✔ ¿Mi pareja me avergüenza o humilla?
- ✔ ¿Mi pareja me amenaza, me lastima, o me hace sentir miedo?
- ✔ ¿Mi pareja me hace que haga cosas sexuales que yo no quiero?
- ✔ ¿Mi pareja me amenaza con hacer daño a mis hijos o mi familia?

Si usted contestó SÍ a algunas de estas preguntas, usted no merece ser lastimada y su visitador domiciliario puede apoyarle y conectarle con programas de ayuda.

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Conozca sus derechos.

¿Qué es lo que tiene que reportar su visitador domiciliario a las autoridades?

- Abuso infantil y negligencia.
- Algunos estados requieren que la violencia doméstica sea reportada a la policía, otros no la requieren.
- Algunos estados tienen leyes que consideran la violencia doméstica y/o el abuso de sustancias como abuso infantil y este puede resultar en un informe al bienestar de menores.

Usted tiene el derecho de saber lo que su visitador domiciliario está requerido a reportar. Pregunte a su visitador domiciliario sobre qué es reportable y a quién.

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Estrategias de afrontamiento

¿Cómo está su salud? ¿Cómo está haciendo frente? Pregúntese:

- ✔ ¿Me siento tan triste que no puedo levantarme de la cama, o cuidar del bebé?
- ✔ ¿Estoy fumando más para calmarme?
- ✔ ¿Estoy tomando alcohol, medicamentos con receta, u otras drogas para aliviar el dolor?
- ✔ ¿Alguna vez me he sentido tan triste que he pensado en el suicidio?

Si usted contestó SÍ a algunas de estas preguntas, puede ser el resultado del estrés crónico. Hable con su visitador domiciliario inmediatamente sobre cómo obtener ayuda.

How is it Going?

All moms deserve healthy relationships. Ask yourself:

- ✔ Do I feel respected, cared for and nurtured by my partner?
- ✔ Does my partner give me space to be with friends or family (or to take breaks from the baby)?
- ✔ Does my partner support my decisions about if or when I want to have more children?

If you answered *YES* to any of these questions, it is likely that you are in a healthy relationship. Studies show that this kind of relationship leads to better health, longer life, and better outcomes for children.

On Bad Days?

Is my relationship unsafe or disrespectful? Ask yourself:

- ✔ Does my partner shame or humiliate me?
- ✔ Does my partner threaten me, hurt me, or make me feel afraid?
- ✔ Does my partner make me do sexual things I don't want to?
- ✔ Does my partner threaten to hurt my children or my family?

If you answered *YES* to any of these questions, you don't deserve to be hurt and your home visitor can support you and connect you to helpful programs.

Know Your Rights

What does your home visitor have to report to the authorities?

- Child abuse and neglect.
- A few states require that domestic violence must be reported to the police, others do not.
- A few states have laws that view domestic violence and/or substance abuse as child abuse and this can result in a report to child welfare.

You have the right to know what your home visitor is required to report. Ask your home visitor about what is reportable and to whom.

Coping Strategies

How is your health, how are you coping? Ask yourself:

- ✔ Do I feel so sad I can't get out of bed? Or take care of the baby?
- ✔ Am I smoking more to try and calm myself?
- ✔ Am I using alcohol, prescription medications, or other drugs to make the pain go away?
- ✔ Do I ever feel so sad that I have thoughts of suicide?

If you answered *YES* to any of these questions, it may be the result of chronic stress. Talk with your home visitor right away about how to get help.

RELATIONSHIP ASSESSMENT TOOL

The Relationship Assessment Tool is a screening tool for intimate partner violence (IPV). The tool, developed by Dr. Paige Hall and colleagues in the 1990's, was originally named the WEB (Women's Experiences with Battering). Terminology has since evolved in the field and the unique characteristic of this assessment tool which measures women's experiences in abusive relationships is more accurately reflected by using the name, Relationship Assessment Tool. References in the literature and publications use the original name, the WEB. The Relationship Assessment Tool and the WEB are the same tool and therefore supported by the same validation studies and research.

As opposed to focusing on physical abuse, the Relationship Assessment Tool (WEB) assesses for emotional abuse by measuring a woman's perceptions of her vulnerability to physical danger and loss of power and control in her relationship. Research has shown that the tool is a more sensitive and comprehensive screening tool for identifying IPV compared to other validated tools that focus primarily on physical assault. Evaluation studies of the Tool have demonstrated its effectiveness in identifying IPV among African-American and Caucasian women. The Relationship Assessment Tool (WEB) has not been validated with same sex partners; it can be adapted for use with same sex couples by changing "he" to "my partner" in the screening tool.

This tool can be self-administered or used during face-to-face assessment by a provider. A series of 10 statements ask a woman how safe she feels, physically and emotionally, in her relationship. The respondent is asked to rate how much she agrees or disagrees with each of the statements on a scale of 1 to 6 ranging from disagree strongly (1) to agree strongly (6). The numbers associated with her responses to the 10 statements are summed to create a score. A score of 20 points or higher on this tool is considered positive for IPV.

PUBLICATIONS ABOUT THE WEB:

Coker AL, Pope BO, Smith PH, Sanderson M, Hussey JR. Assessment of clinical partner violence screening tools. Journal of the American Medical Women's Association. 2001(winter):19-23.

Smith PH, Thorton GE, DeVellis R, Earp JL, Coker AL. A population-based study of the prevalence and distinctness of battering, physical assault, and sexual assault in intimate relationships. Violence Against Women. 2002;8(10):1208-1232.

Smith PH, Earp JL, DeVellis R. Measuring battering: Development of the Women's Experience with Battering (WEB) scale. Women's Health: Research on Gender, Behavior, and Policy. 1995;1(4):273-288.

Appendix G

RELATIONSHIP ASSESSMENT TOOL

Date: _____

This is a self-administered tool for clients to fill out. If the client was unable to complete this tool today, was it because other people were present in the home? Circle one: **Yes/No**

Other reason for not using tool today: _____

_____

(Note to home visitor: Please modify this script based on your state laws. This is just a sample script.)

"Everything you share with me is confidential. This means what you share with me is not reportable to child welfare, INS (Homeland Security) or law enforcement. There are just two things that I would have to report- if you are suicidal, or your children are being harmed. The rest stays between us and helps me better understand how I can help you and the baby."

We ask all our clients to complete this form. For every question below, please look at the scale and select the number (1-6) that best reflects how you feel.

1	2	3	4	5	6
Disagree Strongly	Disagree Somewhat	Disagree a Little	Agree a Little	Agree Somewhat	Agree Strongly

1) My partner makes me feel unsafe even in my own home..... _____

2) I feel ashamed of the things my partner does to me..... _____

3) I try not to rock the boat because I am afraid of what my partner might do..... _____

4) I feel like I am programmed to react a certain way to my partner..... _____

5) I feel like my partner keeps me prisoner..... _____

6) My partner makes me feel like I have no control over my life, no power, no protection _____

7) I hide the truth from others because I am afraid not to ..... _____

8) I feel owned and controlled by my partner ..... _____

9) My partner can scare me without laying a hand on me ..... _____

10) My partner has a look that goes straight through me and terrifies me..... _____

Thank you for completing this survey. Please give it back to your home visitor so they can complete the second page.

Adapted from: Smith, P.H., Earp, J.A., and DeVellis, R. (1995). Measuring battering: development of the Women's Experience with Battering (WEB) Scale. Women's Health: Research on Gender, Behavior, and Policy, 1(4), 273-288.

Documentation and Referral

Home visitors complete the next section:

1) What referrals and information were given to the client this session? (Please note, ALL clients should have been given the *Healthy Moms, Happy Babies* safety card).

(Circle all that apply)

- Social Worker/Counselor
- Domestic Violence Hotline
- Local Domestic Violence Advocate/Program
- *Healthy Moms, Happy Babies* Safety Card
- Other (please specify):_____

2) Did you offer safety planning? (This should happen for any score higher than 20 for pages one and two)

(Circle all that apply)

- Reviewed **Safety Planning** panel on *Healthy Moms, Happy Babies* card.
- Provided the *Safety Plan and Instructions* tool to my client.
- Provided domestic violence hotline numbers.
- Referred to domestic violence advocate for additional safety planning.
- Other (please specify): _____

HERRAMIENTA PARA ASESORAR RELACIÓN

Fecha: _____

Esta es una herramienta autoadministrada para que la llenen las clientas. Si la clienta no pudo llenar esta herramienta hoy, ¿fue porque otras personas estaban presentes en la casa? Circule uno: **Sí/No**

Alguna otra razón por la que no usó esta herramienta hoy: _____

_____

(Nota para visitante de casa: Favor de modificar el guión basado en sus leyes estatales. Este sólo es un ejemplo de guión)

"Todo lo que comparta conmigo es confidencial. Esto quiere decir que lo que usted comparta conmigo no es reportable al bienestar de menores, Departamento de Seguridad Nacional (Inmigración) o la policía. Sólo hay dos cosas que yo necesitaría reportar, si quiere suicidarse, o si sus hijos están siendo dañados/maltratados. El resto de la conversación se mantendrá entre nosotros y ayudame en entender cómo yo puedo ayudar a usted y su bebé mejor."

Le pedimos a nuestras clientas que completen esta forma. Por cada pregunta abajo, favor de ver la escala y seleccione el numero (1-6) que mejor refleje como se siente.

1	2	3	4	5	6
Desacuerdo Fuertemente	Desacuerdo Más o Menos	Desacuerdo Un Poco	De Acuerdo Un Poco	De Acuerdo Más o Menos	De Acuerdo Fuertemente

1) Mi pareja me hace sentir insegura hasta en mi propia casa ..... _____

2) Me siento avergonzada de las cosas que me hace ..... _____

3) Trato de evitar problemas, porque temo de lo que pueda hacer ..... _____

4) Siento que estoy programada a reaccionar de cierta manera hacia él/ella ..... _____

5) Siento que me tiene prisionera..... _____

6) Me hace sentir que no tengo control sobre mi vida, sin poder, sin protección ..... _____

7) Escondo la verdad con los de más porque tengo miedo si no lo hago ..... _____

8) Me siento adueñada y controlada por él/ella..... _____

9) Me puede asustar sin ponerme una mano en sima..... _____

10) Tiene una mirada que me penetra y me aterroriza ..... _____

Gracias por completar esta encuesta. Favor de regresarla a su visitante de casa para que complete la segunda página.

Adaptado por: Smith, P.H., Earp, J.A., and DeVellis, R. (1995). Measuring battering: development of the Women's Experience with Battering (WEB) Scale. Women's Health: Research on Gender, Behavior, and Policy, 1(4), 273-288.

Herramienta para Asesorar la Relación (página 2)

Visitantes de casa, completen la siguiente sección:

1) ¿Qué referencias e información se le dieron a la clienta en esta sesión? (Nota importante, se le deben de dar a TODAS las clientes la tarjeta de seguridad Mamás Sanas, Hijos Felices)

(Circule todo lo que aplique)

- Trabajadora Social/Consejera
- Línea Directa de Violencia Doméstica
- Programa/Consejera de Violencia Doméstica Local
- Tarjeta de seguridad: Mamás Sanas, Hijos Felices
- Otro (favor de especificar):_____

2) ¿Ofreció apoyo con plan de seguridad? (Esto debe ocurrir para cualquier puntuación arriba de 20, para páginas 1 y 2)

(Circule todo lo que aplique)

- Revisamos el panel de **planeación de seguridad** en la tarjeta Mamás Sanas, Hijos Felices.
- Se le dio a mi clienta la herramienta de Plan de Seguridad e Instrucciones.
- Se le dieron números de líneas directas de violencia doméstica
- Se le refirió a una consejera de violencia doméstica para planeación de seguridad adicional.
- Otro (favor de especificar): _____

SAFETY PLAN AND INSTRUCTIONS

SAFETY PLAN

Step 1:

Safety during a violent incident. I can use some or all of the following strategies:

- **A.** If I have/decide to leave my home, I will go_____ .
- **B.** I can tell_____ (neighbors) about the violence and request they call the police if they hear suspicious noises coming from my house.
- **C.** I can teach my children how to use the telephone to contact the police.
- **D.** I will use _____as my code word so someone can call for help.
- **E.** I can keep my purse/car keys ready at (place) _____, in order to leave quickly.
- **F.** I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Step 2:

Safety when preparing to leave. I can use some or all of the following safety strategies:

- **A.** I will keep copies of important documents, keys, clothes and money at_____.
- **B.** I will open a savings account by _____, to increase my independence.
- **C.** Other things I can do to increase my independence include:_____ .
- **D.** I can keep change for my phone calls on me at all times. I understand that if I use my telephone, credit card, or cell phone, the telephone bill or phone log will show my partner the numbers that I called after I left.
- **E.** I will check with _____ and my advocate to see who would be able to let me stay with them or lend me some money.
- **F.** If I plan to leave, I won't tell my abuser in advance face-to-face, but I will leave a note or call from a safe place.

Step 3:

Safety in my own residence (some of these things can be paid for by Victim of Crime Dollars for more information www.ncjrs.gov/ovc_archives/factsheets/cvfvca.htm). Safety measures I can use include:

- **A.** I can change the locks on my doors and windows as soon as possible.
- **B.** I can replace wooden doors with steel/metal doors.
- **C.** I can install additional locks, window bars, poles to wedge against doors, and electronic systems etc.
- **D.** I can install motion lights outside.
- **E.** I will teach my children how to make a collect call to me if my _____ partner takes the children.
- **F.** I will tell people who take care of my children that my partner is not permitted to pick up my children.
- **G.** I can inform _____(neighbor) that my partner no longer resides with me and they should call the police if he is observed near my residence.

Safety Plan and Instructions (page 2)

Step 4:

Safety with a protection order. The following are steps that help the enforcement of my protection order.

A. Always carry a certified copy with me and keep a photocopy.

B. I will give my protection order to police departments in the community where I work and live.

C. I can get my protection order to specify and describe all guns my partner may own and authorize a search for removal.

Next Step INSTRUCTIONS

Legal Considerations…

- Domestic Violence is a crime and you have the right to legal intervention. You should consider calling the police for assistance. You may also obtain a court order prohibiting your partner from contacting you in any way (including in person or by phone). Contact a local DV program or an attorney for more information.
- If you have injuries, ask a doctor or nurse to take photos of your injuries to become part of your medical record.

CALLING THE POLICE*

When someone has injured you or violated a restraining order, criminal stay-away order or emergency protective order, do the following:

1) Call the police at 911, if it is an emergency. Tell them you are in danger and you need help immediately. Let them know if you have a court order. If the police do not come quickly, call again and say "This is my second call." Note the time and date of your call(s).

2) When the police arrive, tell them only what your partner or ex-partner did. Describe your injuries, how you were injured or how he violated a restraining order, and if your partner or ex-partner used weapons. If he has violated a restraining order, show the police your order and any proof of service. Ask that the police file a report and give you a report number.

3) Tell the officers that the attacker will come back and beat you unless they make an arrest. If the police make an arrest and take the attacker into custody, you should be aware that he/she could be released within a few hours. You can use those hours to get to a safer place.

4) If you don't have a restraining order or an injunction for protection, ask the officer for an Emergency Protective Order. This is an order that may protect you until you obtain a criminal stay-away order or restraining order.

5) Always get the police officers' names and badge numbers. If you have trouble with a police o fficer, you can complain directly to the Chief of Police or to the officer's supervisor.

6) If the violator is arrested and taken to the police station, he/she may be charged and he/she will probably be released on bail or, in certain circumstances, without bail until the hearing. Ask that a condition of his release be that he should not come near you. This process may take from 2 to 48 hours.

7) If the violator is not arrested you should call the prosecutor or police department about how to follow-up with your complaint.

8) Keep a journal documenting what happened.

PLAN DE SEGURIDAD E INSTRUCCIONES

PLAN DE SEGURIDAD

1er paso:

Seguridad durante un incidente de violencia. Puedo usar algunas o todas de las siguientes estrategias:

A. Si decido o tengo que irme del hogar, iré a _____.

B. Puedo avisar a _____ (vecinos) acerca del incidente de violencia y pedirles que llamen a la policía si escuchan ruidos sospechosos en mi casa.

C. Puedo enseñarles a mis hijos cómo usar el teléfono para llamar a la policía.

D. Usaré esta palabra _____ como palabra clave para que alguien llame a pedir ayuda.

E. Dejaré una bolsa / llaves del carro preparadas en (ubicación) _____, para poder irme rápido.

F. Usaré mi juicio e intuición. Si la situación se pone muy grave, le daré a mi pareja lo que pida para poder calmarlo/a. Tengo que protegerme hasta que esté o estemos fuera de peligro.

2º paso:

Seguridad al prepararse para irse de la casa. Puedo usar algunas o todas de las siguientes estrategias de seguridad:

A. Guardaré copias de documentos importantes, llaves, ropa y dinero en _____.

B. Abriré una cuenta de ahorros antes del (fecha) _____, para tener más independencia.

C. Otras formas de aumentar mi independencia incluyen lo siguiente: _____.

D. Siempre tendré a la mano monedas para hacer llamadas telefónicas. Entiendo que si uso mi teléfono, tarjeta de crédito o teléfono celular, mi pareja podrá ver en la factura telefónica una lista de llamadas con los números telefónicos que llamé, después de irme de la casa.

E. Me pondré en contacto con _____ y mi asesor para ver quien podría alojarme o prestarme dinero.

F. Si planeo irme, no le avisaré con anticipación a mi agresor, tampoco le diré cara a cara. Pero le dejaré una nota o lo llamaré desde un lugar seguro.

3er paso:

Seguridad en mi propia casa (el Fondo de Víctimas del Delito puede pagar algunos de estos costos. Para más información consulte: www.ncjrs.gov/ovc_archives/factsheets/cvfvca.htm). Las medidas de seguridad que puedo usar incluyen:

A. Puedo cambiar las cerraduras de las puertas y las ventanas lo antes posible.

B. Puedo reemplazar las puertas de madera por puertas de acero o de metal.

C. Puedo instalar cerraduras adicionales, rejas para las ventanas, travesaños para las puertas y sistemas de seguridad electrónicos, etc.

D. Puedo instalar en el exterior de la casa un sistema de alumbrado sensible al movimiento.

E. Les enseñaré a mis hijos a llamarme por cobrar si mi pareja se lleva los niños.

F. Les diré a las personas que cuidan a mis hijos que mi pareja no tiene permitido recoger a mis hijos.

G. Puedo informar a _____ (vecino) que mi pareja ya no vive conmigo y deberían llamar a la policía si lo ven cerca de mi casa.

Plan de Seguridad e Instrucciones (página 2)

4º paso:

Seguridad con una orden de protección. Los siguientes son pasos que pueden ayudar a hacer cumplir la orden de protección.

A. Siempre lleve consigo una copia certificada de la orden de protección y guarde una fotocopia.

B. Entregaré mi orden de protección al departamento de policía de la comunidad donde vivo y trabajo.

C. Puedo pedir que mi orden de protección especifique y describa las armas que tiene mi pareja para autorizar un registro de la casa para quitárselas.

Próximo paso INSTRUCCIONES

Consideraciones legales…

- La violencia en el hogar es un delito y usted tiene derecho a solicitar una intervención judicial. Piense en llamar a la policía para pedirles ayuda. Usted también puede obtener una orden del tribunal que prohíba a su pareja a comunicarse con usted de cualquier forma (personalmente o por teléfono). Para obtener más información, comuníquese con el programa local de violencia en el hogar o con un abogado.
- En caso de estar herida y tener alguna lesión, pídale a un doctor o enfermera que tomen fotos de sus heridas para que formen parte de su informe médico.

LLAMAR A LA POLICÍA*

Si se encuentra herida o si su agresor violó una orden de restricción, orden de alejamiento o una orden de protección de emergencia, haga lo siguiente:

1) Si se trata de una emergencia, llame a la policía o al 911. Dígales que está en peligro y que necesita ayuda inmediatamente. Infórmeles que tiene una orden del tribunal. Si la policía no llega rápido, llame otra vez y diga: “Ésta es mi segunda llamada”. Lleve un registro de la hora y el día de sus llamadas.

2) Una vez que la policía esté en su casa, infórmeles solamente lo que su pareja o ex pareja hizo. Describa sus heridas, cómo se causaron o de qué forma su pareja violó la orden de restricción, y si su pareja o ex pareja usó algún tipo de arma. Si violó una orden de restricción, muéstrele a la policía la orden y prueba de entrega, si la tiene.

3) Dígale a la policía que si no detienen a su agresor, que volverá a atacarla de nuevo. Si la policía detiene al agresor y lo ponen bajo custodia, tenga en cuenta que lo podrán poner en libertad en pocas horas. Puede usar ese tiempo para ir a un lugar más seguro.

4) Si no tiene una orden de restricción o de protección, pida una Orden de Protección de Emergencia al agente. Esta es una orden que la protegerá hasta que obtenga una orden de alejamiento o una orden de restricción.

5) Siempre pida los nombres y números de identificación a los policías. Si tiene algún problema con un policía, podrá presentar una queja directamente al Jefe de Policía o al supervisor del agente.

6) Si detienen al agresor y lo llevan al departamento de policía, es posible que presenten cargos en su contra y luego lo dejan en libertad bajo fianza, o en algunos casos sin fianza, hasta la fecha de la audiencia en la corte. Pídales como condición de su libertad, que no permitan al agresor acercarse a usted. Este proceso toma entre 2 y 48 horas.

7) Si no detienen al agresor comuníquese con el fiscal o el departamento de policía para que le indiquen como hacer el seguimiento de su denuncia.

8) Tome apuntes para documentar lo que sucedió.

SAMPLE MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding (MOU) Between Home Visitation and Domestic Violence Programs

Background

Home visitation programs are case management programs designed for pregnant and parenting mothers of small children. These voluntary programs have been created for low-income mothers to support their parenting and infant/toddler care through health education and by providing linkages to local services. Home visitation programs help mothers with a range of issues, one of which is domestic violence. Many home visitation programs are required to screen for domestic violence and provide referrals to local domestic violence programs and national hotlines.

The goal of this MOU is twofold. The first goal is to help establish a deeper relationship between home visitation and domestic violence programs and support 'warm' referrals. As an example of why deeper program partnerships can make a difference in conversation with clients, we are working with home visitors so referrals are more like: "If you are comfortable with this idea, I would like to call Sherrie from Safe Haven (local DV program), she is really kind and has worked with many, many women in your shoes." Verses—"Here is a hotline number in case you need to call." When personal connections are made between programs it helps clients feel safer accessing support and taking action.

Some home visitation programs have already developed such relationships with their local domestic violence agency. In fact, some partnerships have made it possible for the home visitor to bring the advocate to meet with a woman as part of case management to encourage deeper participation in domestic violence advocacy services. While we recognize that not all programs have this capacity, this partnership can create an opportunity for a direct connection to a domestic violence program that she might otherwise not make.

A second goal in developing a partnership between home visitation and domestic violence services is to create opportunities to connect pregnant and parenting women to home visitation services while they are in shelter. Developing a trusting relationship with the home visitation program is a way to extend support to women beyond shelter and help her connect to case management services that would be more trauma and violence informed through a partnership between agencies.

This recommendation comes with caveats. Of course it would be essential that home visitation staff signed a confidentiality agreement if they were to come to the shelter in the same way advocates do and promise not to reveal the location of the shelter and the location of the mother and her children.

The parties listed above and whose designated agents have signed this document agree that:

1) **_____ (home visitation program) and _____ (domestic violence program) will meet with each other once per year to understand the services currently provided by their respective programs and review referral policies between agencies.**

2) **When domestic violence is identified by home visitation, _____ (home visitation program) will review advocacy services available and provide referral to _____ (domestic violence programs).**

3) **Any home visitor assigned to providing services to pregnant or parenting women at the shelter will complete any/all confidentiality agreements required by the shelter to ensure client safety and to assure that the location of the shelter remain confidential and not shared with ANYONE including friends and family, _____ (home visitation program) will take all precautions to ensure victim/survivor safety and assign staff to work with shelter clients that have training on domestic violence.**

4) **_____ (domestic violence agency) and _____ (home visitation program) agree to work to the amount feasible to ensure that each family has a consistent staff member assigned to assist them and to minimize the transfer of cases involving domestic violence.**

5) **_____ (domestic violence program) agrees to provide every victim/survivor seeking services with safety planning (including safety planning for children) and information on how to meet their basic human needs (such as food, housing and clothing), including offering to connect her to (home visitation program) as part of a supportive case management plan.**

We, the undersigned, approve and agree to the terms and conditions as outlined in this Memorandum of Understanding.

_____	_____
Executive Director Domestic Violence Program	Executive Director Home Visitation Program
_____	_____
Date	Date

POST-TRAINING ASSESSMENT FOR HOME VISITORS

For the purpose of this assessment, the term clients refer to the **adult caregivers/parents** for an infant/child.

Please circle one answer for each of the following questions:

1) **I am familiar with how working with clients who are experiencing domestic or violence and/or other trauma can affect me and my co-workers.**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

2) **I know several self-care strategies that can help to prevent the effects of vicarious trauma when working with families experiencing domestic or sexual violence.**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

3) **I know what local & national resources are available to assist my clients if they have experienced domestic and/or sexual violence.**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

4) **I am familiar with how trauma-informed programming can reduce staff barriers to screening for domestic violence with clients.**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

5) **I have better skills to assess for domestic violence (DV) with my clients then I did at the beginning of today's training.**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

6) **I have the skills to provide universal education for reproductive coercion and birth control sabotage with my clients.**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

7) **I am familiar with the evidence-based safety card approach to educate clients about domestic violence and healthy relationships.**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

8) **I am comfortable talking with my clients about healthy and unhealthy relationships.**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

9) **I have the knowledge to talk with my clients about birth control that is not dependent on a partner (i.e. emergency contraception).**

A. Strongly Disagree **B. Disagree** **C. Neutral** **D. Agree** **E. Strongly Agree**

10) I am confident in my ability to help a client with safety planning when domestic violence is disclosed.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

11) I understand the value of making connections to local DV programs and hotlines.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

12) I understand how mindful movement can be strategy for my own self-regulation and my clients.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

Following the training today, I am more likely to:

13) Integrate universal education, using the safety card approach, into domestic violence (DV) screening with my clients.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

14) Consider calling the domestic violence hotline or referring my client to it if they needed help.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

15) Provide information about DV/SV/CEV to all my home visitation clients.

A. Strongly Disagree B. Disagree C. Neutral D. Agree E. Strongly Agree

16) Please circle at least one action item that you intend to do differently following the training today (circle as many as apply):

A. Make safety cards related to DV/SV available to all home visitation clients
B. Discuss reproductive coercion with my clients
C. Continually check myself about the way I introduce materials and screening tools connected to DV (how the tools or questions are framed matter)
D. Work with our home visitation program to insert a prompt into our intake and follow up forms to include assessment for domestic and sexual violence (DV/SV)
E. Offer an in-service training for all home visitation staff on trauma informed DV
F. Set up a home visitation protocol for assessing for DV/SV/CEV with home visits
G. Other (please be as specific as you can): _____

_____

_____

_____

_____

_____

_____

Post-Training Assessment for Home Visitors

17) What support do you need to incorporate discussion of domestic and sexual violence (DV/SV) and childhood exposure to violence (CEV) in all your home visitation encounters?

_____

_____

_____

18) What was the most useful/valuable part of this training for you?

_____

_____

_____

19) What was the least useful/valuable part of this training for you?

_____

_____

_____

20) What is one thing you would change to improve this training?

_____

_____

_____

Additional Comments: _____

_____

_____

_____

Thank you for your time, expertise and the work you do.

Appendix J

Our vision is now our name.

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