# Florida Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Intimate Partner Violence Screening, Support, and Referral Learning Collaborative

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## Executive Summary

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative implemented an intimate partner violence (IPV) learning collaborative to fulfill a need for a more comprehensive approach to IPV in order to improve performance on HRSA required benchmarks. This collaborative involved three learning sessions, periodic webinars on specific IPV topics, and program implementation of continuous quality improvement (CQI) methods (plan, do, study, act [PDSA] cycles) to test program improvements. Also, MIECHV staff concurrently participated in monthly site specific data collection regarding screenings, referrals and safety planning during the learning collaborative. The rates of these were observed to increase except that of screening which remained on a plateau. Home visitors' system awareness and knowledge was tested before beginning the collaborative session and again after the second collaborative session. All MIECHV staff participants (supervisors/administrators and home visitors) were grouped into breakout sessions during each of the collaborative sessions to discuss their experiences in participating in the learning collaborative, including successes and challenges. This report describes baseline, midpoint, and post-collaborative levels of confidence, system awareness, and knowledge of home visitors regarding IPV service delivery. It also highlights themes that emerged during the breakout sessions.

At baseline the levels of confidence, system awareness, and knowledge of IPV service delivery varied among participants. Following the second learning session, there was an overall increase in confidence and system awareness of home visitors. Highest increases were noted for home visitors' level of preparedness to serve families affected by IPV; their confidence in knowing how to act when a client discloses IPV experience; their confidence in screening participants; their awareness of the name of a staff person at the local domestic violence center who they could reach out to for help; and knowledge on notifying an IPV survivor prior to making a child abuse report. Levels of confidence and system awareness continued to increase at survey 3, with little change in knowledge scores. In particular, survey 3 respondents reported higher confidence in identifying red flags for IPV, screening, and safety planning. Survey 3 respondents also reported more familiarity with legal options for IPV survivors, knowing when to report IPV, and knowing a staff person at the DV center. The Survey 3 respondents also appeared to have a greater knowledge that IPV includes more than physical abuse, and understanding of why a person may stay in an abusive relationship.

During the first breakout session, supervisors/administrators talked about how to be successful in their supportive roles especially when working with families that are not particularly forthcoming, as well as how and what it means to initiate a trusting relationship and how to redefine success. Home visitors discussed the need for more education, better screening tools and strategies, impact of IPV on children, and increasing awareness of IPV among program staff and participants. The second breakout session involved supervisors/administrators discussing the need for policies on workplace violence, the impact of IPV on staff, the importance of staff support through reflective supervision and organizational supports, and safety in home visiting environments. In addition, discussions around self-care and stress management were the focus of the second breakout session for home visitors. For the third learning session, mixed groups with home visitors, supervisors, and administrators discussed successes (e.g., personal stories, guest presentations, and data training) and challenges of the learning collaborative. Furthermore, strategies used in sharing information from the learning collaborative, as well as challenges and suggestions for improvement were discussed. Lastly, strategies for sustainability including policy development in addition to developing and implementing staff training were highlighted, and the groups discussed next steps to continue to improve IPV service delivery. It is recommended that programs continue to develop and implement policies, procedures, and strategies to improve IPV screening, support, and referral using the knowledge and skills gained from the learning collaborative.

## Introduction

Intimate partner violence is an important issue that has several implications for maternal and child health. It has been associated with poor maternal, physical, mental, and sexual health, as well as increased risk for preterm delivery, low birth weight, neonatal death, and reduced breastfeeding rates.[1-3] Additionally, children exposed to violence have been shown to have adverse physical, emotional, behavioral, social, and cognitive outcomes including increased physical distress, eating and sleeping problems, post-traumatic stress disorder (PTSD), depression, low self-esteem, academic problems, and increased suicidality.[4, 5] It is essential to have effective programs that identify and intervene in cases of IPV to reduce the risks of these adverse effects.

One of the components of the Florida MIECHV Initiative is to offer support to families experiencing or at-risk for IPV. This process includes screening and detection of ongoing IPV, creating safety plans, and providing ongoing support, as well as referrals to certified domestic violence centers. The Florida MIECHV benchmarks related to IPV include: 1) Maintain or increase the percent of women screened for domestic violence within 6 months of enrollment; 2) Maintain or increase the percent of women who are referred for domestic violence services within seven days of screening positive for domestic violence; and 3) Maintain or increase the percent of women who have a safety plan within one month of screening positive for domestic violence. The Florida MIECHV State CQI Team determined that a more comprehensive approach to improving performance on IPV-related benchmarks was needed and set up a learning collaborative modeled after the Institute for Healthcare Improvement Breakthrough Series towards this end. The purpose of this report is to discuss changes in levels of knowledge, system awareness, and confidence among Florida MIECHV home visitors regarding IPV screening and supporting families experiencing IPV; describe the content of the three learning sessions; and highlight key themes emerging from the breakout sessions/focus groups with home visitors and supervisors/administrators during these sessions.

## Methods

### *Continuous Quality Improvement (CQI) – MIECHV Site Activities*

Each MIECHV site is responsible for developing their unique IPV procedures based on model type, system of care and what works for them. As part of the learning collaborative, each site was expected to use the Model for Improvement (rapid cycle testing using Plan-Do-Study-Act). Below are strategies tested by participating sites to achieve improvement and some of the activities that took place during the learning collaborative.

Broward: Home visitors did not have many positive screens using the Relationship Assessment Tool (RAT) and the MIECHV Domestic Violence Form, but will continue refining and testing their draft IPV policy with more home visitors prior to implementation.

Escambia: IPV screening rates were significantly improved by testing the use of a color coded list of MIECHV due dates, including the HARK. The HARK is a four item questionnaire used to identify women experiencing IPV. This will be used to develop an implementation plan.

Hillsborough: Staff agreed on their final IPV policy and are on the verge of adoption. They plan to change the policy language slightly and adopt it for their system of care based on survey results.

Manatee: Staff found, through multiple cycles, that using their healthy relationship pretest and healthy relationship curriculum prior to administering the RAT screening was a relationship building tool. It encouraged families to talk more extensively about their relationships which may ultimately aid in detecting IPV if it exists. They also learned that families had a better understanding of healthy relationships.

Miami-Dade: Staff focused on using a script to introduce the NFP Relationship Assessment Tools based on positive feedback from the nurse home visitor. They predicted that this would increase positive disclosures.

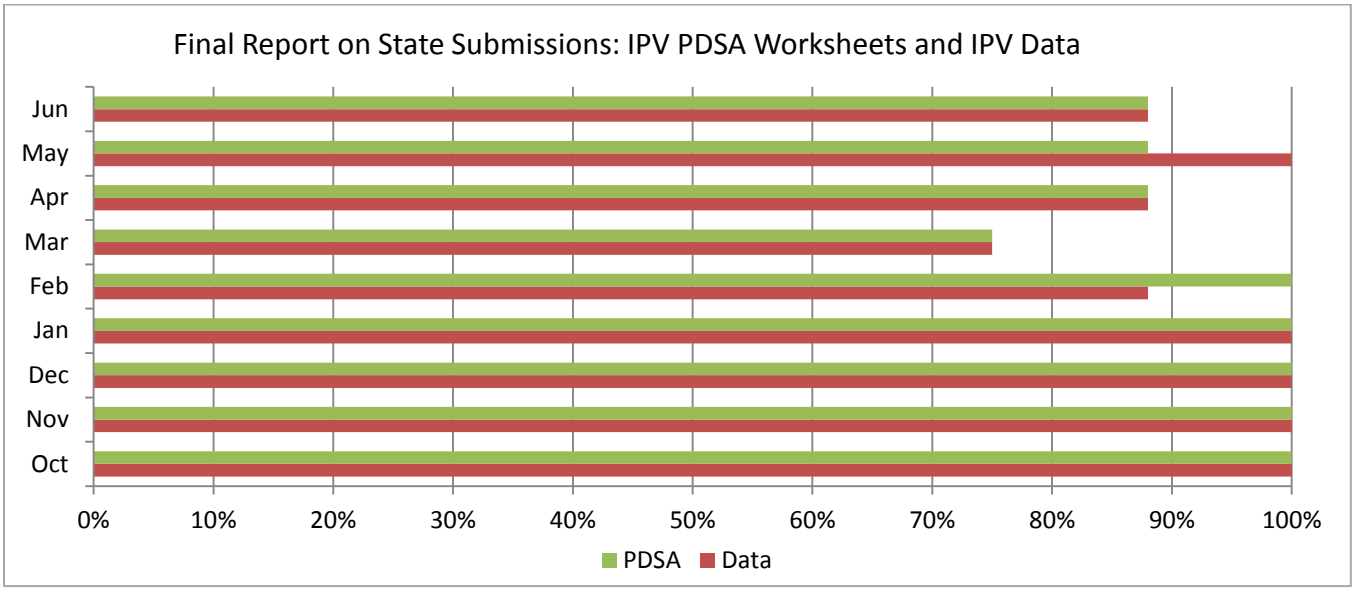
North Central: Staff tested the efficacy of their referral process to the local DV Center by surveying active participants who had a positive screen or IPV disclosure since July 2015. The completed surveys showed that the

current process is working well for most survivors. One significant discovery way a need to specify and strengthen the protocol for referring participants that do not speak English. They plan to implement the new referral process by adding it to their policies.

Orange: Staff received a refresher training and were measured on their comfort level in administering the HARK screen. The refresher training increased their level of comfort with HARK administration and they are planning on implementing the same training for new staff and current staff as needed.

Southwest Florida: Staff completed testing of the segue conversation, the DV Education and Screening Guidelines. As predicted, the standardized DV Education/Screening Guidelines and script increased the comfort levels of home visitors. They tested at multiple sites with multiple home visitors and paid attention to both positive and negative feedback. They are ready to implement the Guidelines and script program-wide.

IPV PDSA reports and data on screening, referral and safety planning rates were submitted to the Florida MIECHV Initiative state staff via Groupsite on a monthly basis. Almost ninety percent of the MIECHV sites consistently submitted their monthly IPV PDSA reports and data respectively by the due date.




### *Home Visitor Survey - Confidence, System Awareness, and Knowledge in Addressing IPV*

A brief survey developed by the state CQI team and reviewed by an expert panel was distributed via email, with a link to the Qualtrics online survey software platform, to all home visitors working in nine of the 11 Florida MIECHV programs. Two programs were excluded because of their participation in the national Home Visiting Collaborative Improvement and Innovation Network [HV CoIIN] prior to the first learning session. The survey collected baseline information on participants' program affiliation, previous training experience, and questions to assess confidence, system awareness, and knowledge pertaining to IPV service delivery. A similar survey was distributed to all home visitors after the second and third learning sessions to assess changes in their confidence, system awareness, and knowledge regarding IPV service delivery. Descriptive statistics (percentages) were computed for baseline and subsequent confidence, system awareness, and knowledge of survey respondents. Fisher's exact test was used to determine if there were significant differences between individuals (1) who had received prior training versus those who did not and (2) who attended the learning sessions/webinars versus those who did not.

### *Learning Sessions – Successes, Challenges, and Lessons Learned*

The learning collaborative included three in-person learning sessions (LS1, LS2, and LS3) which covered various topics related to IPV. These were 2-day sessions done three to four months apart in August, 2015, November, 2015, and March 2016, respectively. During each of the in-person sessions, breakout sessions were conducted. LS1 and LS2 involved breakout sessions with home visitors in one group and supervisors/administrators in the

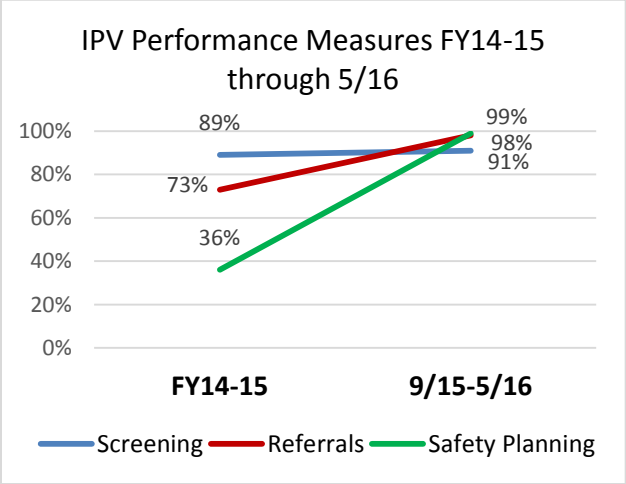
other. LS3 involved mixed breakout sessions with discussions that focused on successes, challenges, and impact of the learning collaborative. These breakout sessions were audio recorded, transcribed, and identified themes summarized.

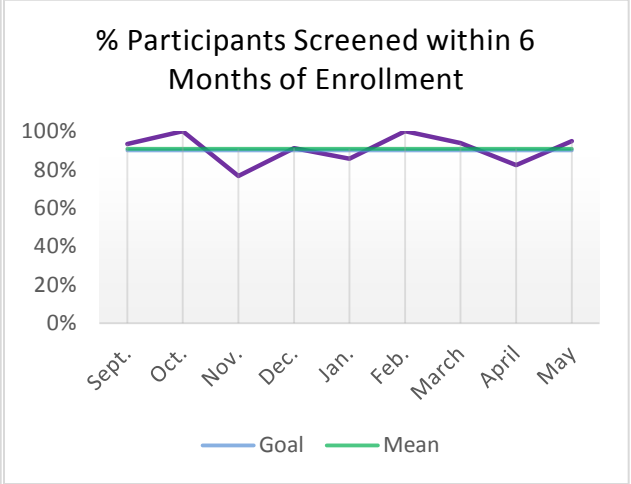
In addition to the learning sessions, home visitors and supervisors/administrators were given opportunities to attend webinars on the following topics:

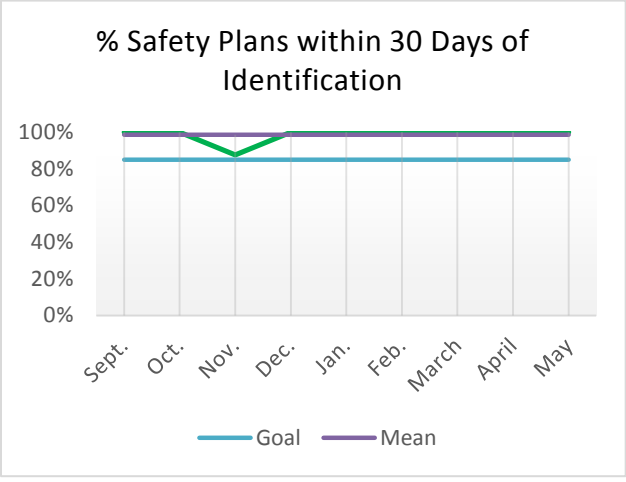
1. Screening and continuous quality improvement
2. Responding to domestic violence in the African-American community
3. Effects of IPV on children and rapid cycle testing
4. IPV among Latinos and working with Hispanic survivors
5. Female to male violence, batterer intervention programs, and CQI update
6. Guide to DV in civil and criminal system and responses to IPV disclosures

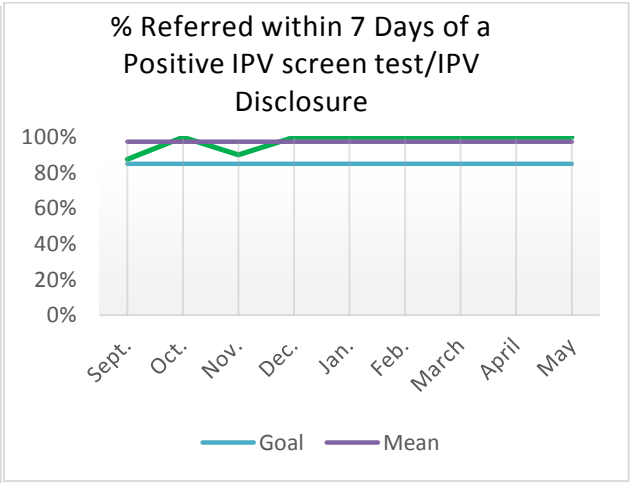
### IPV Performance Measures:

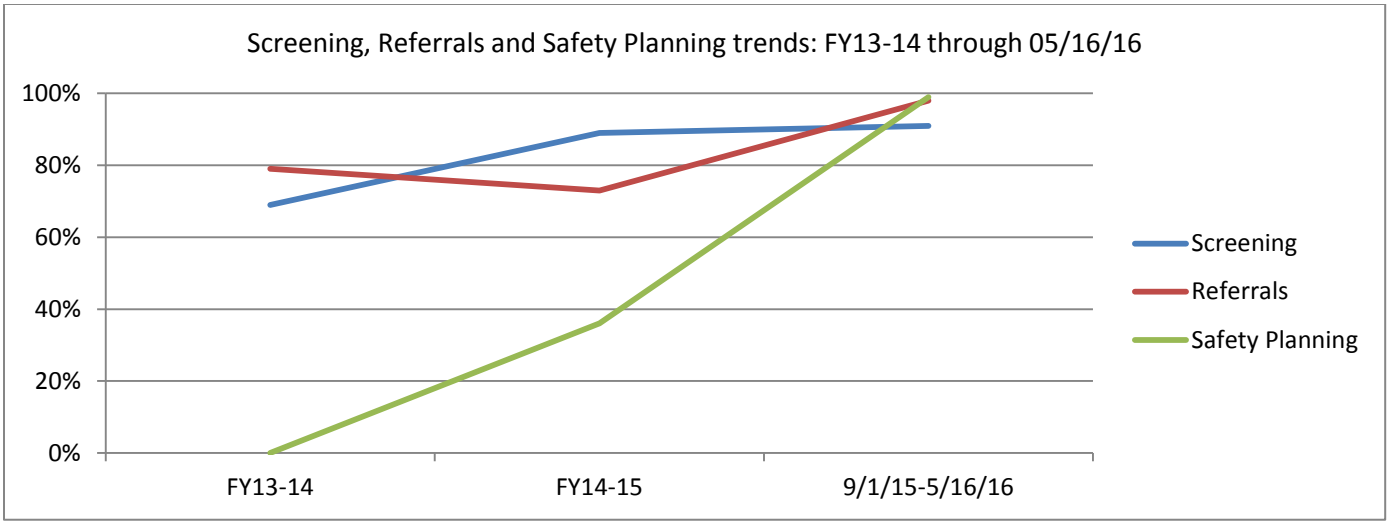
The Florida MIECHV Initiative has different targets set for the different IPV measures (see table 7) and, while some sites still need to work on consistently screening participants within six months of enrollment into the program, the performance goal of 90% screening rate was exceeded with an average (mean) of 91% across all sites. For referrals and safety planning, the Florida MIECHV program achieved 100% since December - well exceeding the 85% goals set for each measure.



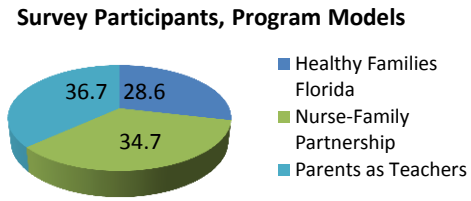



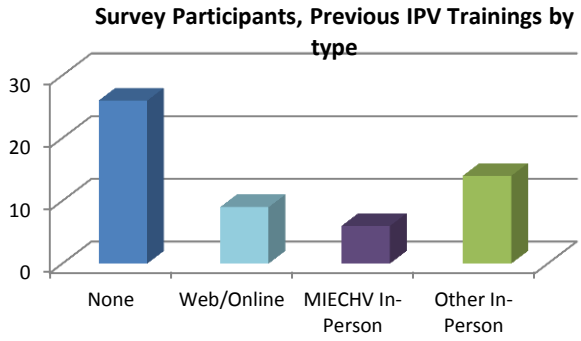



## Baseline Learning Collaborative Survey Results

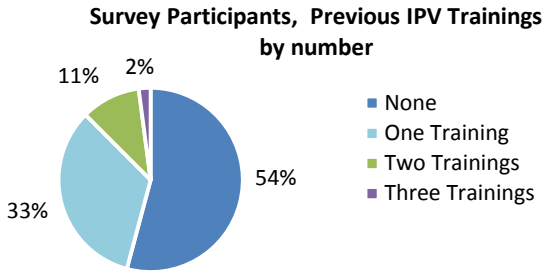
A total of 52 home visitors accessed the survey, and 49 completed the survey in its entirety. Respondents were almost evenly distributed in terms of the program model they were affiliated to. Eighteen home visitors (36.7%) were in programs that implemented the Parents as Teachers model, 17 (34.7%) were in programs based on the Nurse-Family Partnership model, and 14 (28.6%) were in programs that used the Healthy Families Florida model.




### *IPV Training*




At baseline, about 47% (n=23) of the home visitors had received prior IPV training out of which nine had received web/online training, six had received a MIECHV in-person training, while 14 had received an in-person training from another provider [Note: respondents could select more than one option for previous training]. Other sources of in-person training included Department of Children and Families (DCF), Florida Coalition against Domestic Violence (FCADV), Supporting Families Affected by Domestic Violence (two-day MIECHV training), University of Miami Domestic Violence and Sex Trafficking, and a Domestic Violence (DV) and Sexual Abuse program.




The majority of the respondents who had received training (n=16) had participated in one training session prior to the learning collaborative. Other respondents had been involved in more than one training session, with five respondents having participated in two, and one having participated in three sessions in the past.

### *Home Visitors' Confidence, System Awareness, and Knowledge in Addressing IPV*

#### *Confidence*

The levels of confidence in IPV service delivery varied among the home visitors (see Table 1). Overall, more than half of respondents reported high levels of confidence with regards to screening, knowing what to say and do following disclosure, and identifying red flags. Additionally, almost half of the home visitors reported that they feel confident creating safety plans in cases of IPV disclosure, while 42.9% felt they were prepared to serve

families affected by IPV. Furthermore, equal percentages of home visitors reported that their agencies had specific protocols about what to do when a participant discloses IPV, with 51% agreeing while 49% were neutral or disagreed. Among respondents that demonstrated high levels of confidence, those with prior training made up a higher percentage than those without prior training. There were significant differences between home visitors with and without prior training for items related to confidence in screening for IPV, creating a safety plan, and being prepared to serve families affected by IPV (p-value <0.01).

### *System Awareness*

The levels of system awareness also varied among home visitors, with higher levels reported for child abuse (see Table 1). Almost three-fourths of the respondents agreed that they knew when to make a report to the child abuse hotline for IPV, however, lower levels were reported for other items that tested system awareness. About 39% of the respondents reported that they knew the name of a staff person at the local DV center that they could call for assistance, and only 20.4% reported familiarity with criminal and civil legal options for IPV survivors. Among respondents that demonstrated high levels of system awareness, the majority consisted of home visitors with prior training; this difference was, however, significant only for the item testing familiarity with legal options for IPV survivors (p-value=0.02).

### *Knowledge*

Baseline IPV knowledge varied among home visitors (see Table 1). More than half of the respondents correctly answered items that assessed knowledge of types of IPV and factors relating to staying or leaving an abusive relationship. Fewer than half of the respondents, however, correctly answered knowledge items that addressed causes of IPV and treatment or prevention methods. On items testing knowledge of IPV, there were no significant differences between home visitors with and without prior training. Knowledge items were scored out of a total of 9. None of the respondents scored 100%, six scored at least 80%, and 26 at least 50%. Again, those with prior training did not appear to have higher total items correct compared to those without prior training.

**Table 1. Home visitors' confidence, system awareness, and knowledge of intimate partner violence (IPV) service delivery stratified by prior training (Survey 1)**

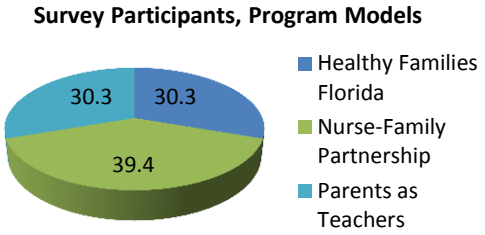
| | Total Indicated Agree/Strongly Agree (N=49) | HV with prior training (N=23) | HV without prior training (N=26) | P-value |
|---|---|---|---|---|
| **Confidence** | | | | |
| I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship | 29 (59.2) | 16 (55.2) | 13 (44.8) | 0.14 |
| I feel confident screening participants for IPV | 28 (57.1) | 18 (64.3) | 10 (35.7) | **<0.01** |
| When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do | 27 (55.1) | 16 (59.3) | 11 (40.7) | 0.05 |
| I feel confident creating a safety plan with participants that disclose IPV | 24 (49.0) | 16 (66.7) | 8 (33.3) | **<0.01** |
| I feel prepared to serve families affected by IPV | 21 (42.9) | 15 (71.4) | 6 (28.6) | **<0.01** |
| **System awareness** | | | | |
| I know when to make a report to the child abuse hotline for IPV | 36 (73.5) | 19 (52.8) | 17 (47.2) | 0.15 |
| I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant | 19 (38.8) | 11 (57.9) | 8 (42.1) | 0.18 |
| I am familiar with the legal options (both criminal and civil) for survivors of IPV | 10 (20.4) | 8 (80.0) | 2 (20.0) | **0.02** |

| Knowledge | N (%) correct | N (%) correct | N (%) correct | P-value |
|---|---|---|---|---|
| All IPV includes physical violence | 39 (79.6) | 20 (51.3) | 19 (48.7) | 0.20 |
| I don't understand why anyone would stay in an abusive relationship | 38 (77.6) | 18 (47.4) | 20 (52.6) | 0.59 |
| I only refer to the local DV center if the participant wants to leave the relationship | 33 (67.3) | 18 (54.5) | 15 (45.5) | 0.11 |
| If the participant chooses to stay in an abusive relationship, there is nothing I can do | 29 (59.2) | 14 (48.3) | 15 (51.7) | 0.53 |
| The primary cause of most IPV is alcohol or drug abuse | 23 (46.9) | 13 (56.5) | 10 (43.5) | 0.16 |
| If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline | 22 (44.9) | 11 (50.0) | 11 (50.0) | 0.46 |
| A problem with anger is the primary cause of IPV | 19 (38.8) | 11 (57.9) | 8 (42.1) | 0.18 |
| Couples counseling is an effective strategy for stopping IPV in families | 15 (30.6) | 8 (53.3) | 7 (46.7) | 0.39 |
| Anger management programs are effective in preventing the recurrence of IPV | 13 (26.5) | 7 (53.8) | 6 (46.2) | 0.40 |

## Mid-point and Post-Learning Collaborative Survey Results

### Learning Session 2:

A total of 37 home visitors accessed the post-intervention survey, and 33 completed the survey in its entirety. Ten (30.3%) respondents were in programs that implemented the Parents as Teachers model, 13 (39.4%) were from programs that used the Nurse-Family Partnership model, and 10 (30.3%) were from programs based on the Healthy Families Florida model.




#### *Previous IPV Training*

Sixteen respondents had attended one or both of the learning sessions. Among these, four (12.5%) and five (15.6%) home visitors had attended LS1 and LS2, respectively, and seven (21.9%) had attended both. Out of 33 home visitors, 11 (33.3%) had not received any other form of training specific to IPV asides from the learning collaborative. More than half of the respondents had participated in three of the four webinars. The webinar on "screening and continuous quality improvement" had been participated in by 19 (57.6%) of the respondents. Similarly, 18 home visitors (54.5%) and 17 home visitors (51.5%) had participated in the webinars "responding to domestic violence in the African-American community" and "effects of IPV on children and rapid cycle testing," respectively. Almost a third of respondents (12) had participated in the webinar "IPV among Latinos and working with Hispanic survivors."

#### *Home Visitors' Confidence, System Awareness, and Knowledge in Addressing IPV*

##### *Confidence*

In this second survey, the home visitors' generally demonstrated high levels of confidence in IPV service delivery (see Table 2). Overall, more than three-quarters of respondents reported high levels of confidence with regards to screening (85%), knowing what to say and do following disclosure (88%), and identifying red flags (82%). About 76% of the home visitors reported that they feel confident creating safety plans in cases of IPV disclosure, while 85% felt they were prepared to serve families affected by IPV. Twenty-nine (87.9%) of the home visitors surveyed reported that their agencies had specific protocols about what to do when a participant discloses IPV.

##### *System Awareness*

The levels of system awareness varied among the respondents with low awareness regarding legal options for IPV (see Table 2). Among respondents, 33.3% reported familiarity with the legal options available for IPV survivors. However, there were high levels of system awareness among other items tested. About 85% of the home visitors agreed that they knew when to make a report to the child abuse hotline for IPV and knew the name of a staff person at their local domestic violence center that they can call if they needed information or assistance for a client (81.8%).

### *Knowledge*

The knowledge of home visitors also varied in the second survey. Less than 50% of respondents had high knowledge regarding the role of anger and services for families affected by IPV. About 49% answered correctly that couples' counseling is *not* an effective strategy for stopping IPV in families, and only 33% answered correctly regarding anger *not* being the primary cause of IPV and anger management *not* being effective in preventing recurrence of IPV. More than 50% of respondents answered correctly for all other knowledge items (see Table 2). Lastly, there was no significant difference in confidence, system awareness, and knowledge of respondents who attended the learning sessions/webinars compared with those who did not (see Table 3).

**Table 2. Home visitors with high confidence, system awareness, and knowledge of IPV service delivery stratified by attendance of learning session (Survey 2)**

| | Total Indicated Agree/Strongly Agree (N=33) | HV who attended LS (N=17) | HV who did not attend LS (N=16) | P-value |
|---|---|---|---|---|
| **Confidence** | | | | |
| I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship | 27 (81.8) | 14 (51.9) | 13 (48.1) | 0.64 |
| I feel confident screening participants for IPV | 28 (84.8) | 13 (46.4) | 15 (53.6) | 0.14 |
| When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do | 29 (87.9) | 16 (55.2) | 13 (44.8) | 0.28 |
| I feel comfortable creating a safety plan with participants that disclose IPV | 25 (75.8) | 13 (52.0) | 12 (48.0) | 0.62 |
| I feel prepared to serve families affected by IPV | 28 (84.8) | 14 (50.0) | 14 (50.0) | 0.53 |
| **System awareness** | | | | |
| I know when to make a report to the child abuse hotline for IPV | 28 (84.8) | 14 (50.0) | 14 (50.0) | 0.53 |
| I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant | 27 (81.8) | 15 (55.6) | 12 (44.4) | 0.30 |
| I am familiar with the legal options (both criminal and civil) for survivors of IPV | 11 (33.3) | 7 (63.6) | 4 (36.4) | 0.27 |
| **Knowledge** | **N (%) correct** | **N (%) correct** | **N (%) correct** | **P-value** |
| All IPV includes physical violence | 29 (87.9) | 15 (51.7) | 14 (48.3) | 0.68 |
| I don't understand why anyone would stay in an abusive relationship | 22 (66.7) | 11 (50.0) | 11 (50.0) | 0.55 |
| I only refer to the local DV center if the participant wants to leave the relationship | 27 (81.8) | 14 (51.9) | 13 (48.1) | 0.50 |
| If the participant chooses to stay in an abusive relationship, there is nothing I can do | 21 (63.6) | 11 (52.4) | 10 (47.6) | 0.59 |
| The primary cause of most IPV is alcohol or drug abuse | 18 (54.5) | 12 (66.7) | 6 (33.3) | 0.06 |
| If possible, I would always notify the IPV survivor | 25 (75.8) | 14 (56.0) | 11 (44.0) | 0.31 |

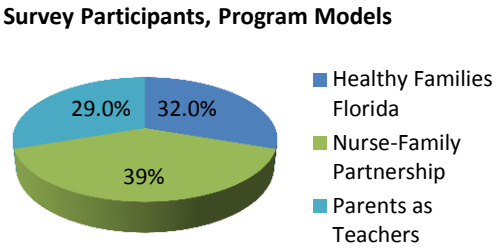
| | | | | |
|---|---|---|---|---|
| prior to making a report to the child abuse hotline | | | | |
| A problem with anger is the primary cause of IPV | 11 (33.3) | 8 (72.7) | 3 (27.3) | 0.09 |
| Couples counseling is an effective strategy for stopping IPV in families | 16 (48.5) | 8 (50.0) | 8 (50.0) | 0.57 |
| Anger management programs are effective in preventing the recurrence of IPV | 11 (33.3) | 5 (45.5) | 6 (54.5) | 0.40 |

**Table 3. Home visitors with high confidence, system awareness, and knowledge of IPV service delivery stratified by attendance of webinars (Survey 2)**

| | Total Indicated Agree/Strongly Agree (N=33) | HV who attended webinar (N=28) | HV who did not attend webinar (N=5) | P-value |
|---|---|---|---|---|
| **Confidence** | | | | |
| I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship | 27 (81.8) | 23 (85.2) | 4 (14.8) | 0.66 |
| I feel confident screening participants for IPV | 28 (84.8) | 23 (82.1) | 5 (17.9) | 0.41 |
| When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do | 29 (87.9) | 25 (86.2) | 4 (13.8) | 0.50 |
| I feel comfortable creating a safety plan with participants that disclose IPV | 25 (75.8) | 21 (84.0) | 4 (16.0) | 0.65 |
| I feel prepared to serve families affected by IPV | 28 (84.8) | 24 (85.7) | 4 (14.3) | 0.59 |
| **System awareness** | | | | |
| I know when to make a report to the child abuse hotline for IPV | 28 (84.8) | 23 (82.1) | 5 (17.9) | 0.41 |
| I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant | 27 (81.8) | 23 (85.2) | 4 (14.8) | 0.66 |
| I am familiar with the legal options (both criminal and civil) for survivors of IPV | 11 (33.3) | 10 (90.9) | 1 (9.1) | 0.41 |
| **Knowledge** | **N (%) correct** | **N (%) correct** | **N (%) correct** | **P-value** |
| All IPV includes physical violence | 29 (87.9) | 24 (82.8) | 5 (17.2) | 0.50 |
| I don't understand why anyone would stay in an abusive relationship | 22 (66.7) | 18 (81.8) | 4 (18.2) | 0.45 |
| I only refer to the local DV center if the participant wants to leave the relationship | 27 (81.8) | 23 (85.2) | 4 (14.8) | 0.60 |
| If the participant chooses to stay in an abusive relationship, there is nothing I can do | 21 (63.6) | 16 (76.2) | 5 (23.8) | 0.09 |
| The primary cause of most IPV is alcohol or drug abuse | 18 (54.5) | 14 (77.8) | 4 (22.2) | 0.23 |
| If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline | 25 (75.8) | 22 (88.0) | 3 (12.0) | 0.35 |
| A problem with anger is the primary cause of IPV | 11 (33.3) | 9 (81.8) | 2 (18.2) | 0.55 |
| Couples counseling is an effective strategy for stopping IPV in families | 16 (48.5) | 13 (81.3) | 3 (18.8) | 0.47 |
| Anger management programs are effective in preventing the recurrence of IPV | 11 (33.3) | 9 (81.8) | 2 (18.2) | 0.57 |

## Learning Session 3:

A total of 28 home visitors accessed the third survey and 26 completed most of the items on the survey. Nine (32%) were of the Healthy Families Florida model, eleven (39%) in program implemented as Nurse Family Partnership while eight (29%) were in the Parent as Teachers model.




### *Previous IPV Training*

Among the respondents who had attended the learning sessions, an equal number (9; 33%) had attended LS1 and LS2, ten (37%) had attended the third LS while nine (33%) had not attended any of the sessions. (Note that more than 1 option can be selected for this item). Slightly over a third, (nine home visitors; 35%), had not received training related to IPV outside of the learning collaborative and of the 65% (17 home visitors) who had training outside of the collaborative, six received such online/via a webinar and 7 (41%) through in person training from Florida MIECHV. The webinar most participated in by the home visitors was "responding to domestic violence in the African-American community" (n= 15; 65%) followed by "screening and continuous quality improvement" (14 home visitors; 61%). Thirteen (57%), twelve (52%) and eleven (48%) home visitors participated in "IPV among Latinos and working with Hispanic survivors", "Female to male violence, batterer intervention programs, and CQI update" and "effects of IPV on children and rapid cycle testing," respectively. Other webinars less participated in were "guide to DV in civil and criminal system and responses to IPV disclosures" (8 home visitors; 35%) and "PDSA practice, mid-point HV survey results, and Florida safety cards" (5 home visitors; 22%).

### *Home Visitors' Confidence, System Awareness, and Knowledge in Addressing IPV*

#### *Confidence*

A general demonstration of high levels of confidence in IPV service delivery was observed in survey 3 (see table 4). Almost all home visitors demonstrated high levels of confidence with respect to screening (92%), know what to say or do when a participant tells of IPV experience (92%) and in identifying red flags in unhealthy relationships (92%) while over four fifths of them reported high confidence in serving families affected by IPV (84%) and creating a safety plan with participants that disclose IPV (81%).

#### *System Awareness*

Similarly, a general high level of system awareness was reported by home visitors in the third distribution of the survey. The lowest awareness was demonstrated in familiarity with legal options for IPV (69%) while almost all HV reported high levels of awareness for items: knowing when to make a report to the child abuse hotline for IPV and knowing the name of a staff person at their local domestic violence center to call if assistance is needed for a participant (96% respectively).

#### *Knowledge*

Responses of home visitors to items relating to knowledge showed a wide variability. Only 36% had knowledge that anger management does not prevent the recurrence of IPV while 50% have the knowledge that IPV is *not* primarily caused by problems with anger. About 56% know that the primary cause of IPV is *not* alcohol and drug abuse. About 65% answered correctly that couples' counseling is *not* an effective strategy for stopping IPV in families and can actually make the situation more dangerous for the survivor. All other knowledge items were answered correctly by the home visitors ranging from 76% - 92%. There was no significant difference in confidence, system awareness, or knowledge of respondents who attended the learning sessions/webinars compared with those who did not (see Tables 3, 4) except for knowing when to refer to the local DV center if the participant wants to leave the relationship stratified by attendance of learning sessions (P-Value 0.006, table 4).

**Table 4: Home visitors with high confidence, system awareness, and knowledge of IPV service delivery stratified by attendance of learning session (Survey 3)**

| | Total (%) Agree/Strongly Agree (N=26) | HV who attended LS (%) (N=17) | HV who did not attend LS (%) (N=9) | P-value |
|---|---|---|---|---|
| **Confidence** | | | | |
| I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship | 24 (92.3) | 16 (66.7) | 8 (33.3) | 0.58 |
| I feel confident screening participants for IPV | 24 (92.3) | 15 (62.5) | 9 (37.5) | 0.42 |
| When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do | 24 (92.3) | 17 (70.8) | 7 (29.2) | 0.11 |
| I feel comfortable creating a safety plan with participants that disclose IPV | 21 (80.8) | 16 (76.2) | 5 (23.8) | 0.34 |
| I feel prepared to serve families affected by IPV[#] | 21 (84.0) | 15 (71.4) | 6 (28.6) | 0.38 |
| **System awareness** | | | | |
| I know when to make a report to the child abuse hotline for IPV | 25 (96.2) | 16 (64.0) | 9 (36.0) | 0.65 |
| I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant[#] | 24 (96.0) | 16 (66.7) | 8 (33.3) | 0.68 |
| I am familiar with the legal options (both criminal and civil) for survivors of IPV | 18 (69.2) | 13 (72.2) | 5 (27.8) | 0.26 |
| **Knowledge** | **N (%) correct** | **N (%) correct** | **N (%) correct** | **P-value** |
| All IPV includes physical violence | 24 (92.3) | 16 (66.7) | 8 (33.3) | 0.58 |
| I don't understand why anyone would stay in an abusive relationship | 22 (84.6) | 15 (68.2) | 7 (31.8) | 0.43 |
| I only refer to the local DV center if the participant wants to leave the relationship[#] | 19 (76.0) | 16 (84.2) | 3 (15.8) | 0.006 |
| If the participant chooses to stay in an abusive relationship, there is nothing I can do | 16 (61.5) | 12 (75.0) | 4 (25.0) | 0.19 |
| The primary cause of most IPV is alcohol or drug abuse[#] | 14 (56.0) | 7 (50.0) | 7 (50.0) | 0.11 |
| If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline | 19 (73.1) | 13 (68.4) | 6 (31.6) | 0.46 |
| A problem with anger is the primary cause of IPV | 13 (50.0) | 8 (61.5) | 5 (38.5) | 0.50 |
| Couples counseling is an effective strategy for stopping IPV in families | 17 (65.4) | 12(70.6) | 5 (29.4) | 0.37 |
| Anger management programs are effective in preventing the recurrence of IPV[#] | 9 (36.0) | 7 (77.8) | 2 (22.2) | 0.37 |

Key: [#]: Item was not answered by one home visitor

**Table 5. Home visitors with high confidence, system awareness, and knowledge of IPV service delivery stratified by attendance of webinars (Survey 3)**

| | Total (%) Agree/Strongly Agree (N= 26) | HV who attended webinar(s) (%) | HV who did not attend webinar(s) (%) | P-value |
|---|---|---|---|---|
| **Confidence** | | | | |
| I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship | 24 (92.3) | 21(87.5) | 3 (12.5) | 0.78 |
| I feel confident screening participants for IPV | 24 (92.3) | 21 (87.5) | 3 (12.5) | 0.78 |
| When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do | 24 (92.3) | 21 (87.5) | 3 (12.5) | 0.78 |
| I feel comfortable creating a safety plan with participants that disclose IPV | 21 (80.8) | 19 (90.5) | 2 (9.5) | 0.49 |
| I feel prepared to serve families affected by IPV[#] | 21 (84.0) | 18 (85.7) | 3 (14.3) | 0.58 |
| **System awareness** | | | | |
| I know when to make a report to the child abuse hotline for IPV | 25 (96.2) | 22 (88.0) | 3 (12.0) | 0.89 |
| I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant[#] | 24 (96.0) | 21 (87.5) | 3 (12.5) | 0.88 |
| I am familiar with the legal options (both criminal and civil) for survivors of IPV | 18 (69.2) | 16 (88.9) | 2 (11.1) | 0.69 |
| **Knowledge** | **N (%) correct** | **N (%) correct** | **N (%) correct** | **P-value** |
| All IPV includes physical violence | 24 (92.3) | 21 (87.5) | 3 (12.5) | 0.78 |
| I don't understand why anyone would stay in an abusive relationship | 22 (84.6) | 19 (86.4) | 3 (13.6) | 0.59 |
| I only refer to the local DV center if the participant wants to leave the relationship [#] | 19 (76.0) | 17 (89.5) | 2 (10.5) | 0.58 |
| If the participant chooses to stay in an abusive relationship, there is nothing I can do | 16 (61.5) | 14 (87.5) | 2 (12.5) | 0.68 |
| The primary cause of most IPV is alcohol or drug abuse[#] | 14 (56.0) | 12 (85.7) | 2 (14.3) | 0.59 |
| If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline | 19 (73.1) | 16 (84.2) | 3 (15.8) | 0.37 |
| A problem with anger is the primary cause of IPV | 13 (50.0) | 12 (92.3) | 1 (7.7) | 0.50 |
| Couples counseling is an effective strategy for stopping IPV in families | 17 (65.4) | 16 (94.1) | 1 (5.9) | 0.27 |
| Anger management programs are effective in preventing the recurrence of IPV[#] | 9 (36.0) | 9 (100.0) | 0 (0.0) | 0.24 |

Key: [#]: Item was not answered by one home visitor

### *Change in Levels of Confidence, System Awareness, and Knowledge after Learning Collaborative*

There was a general increase in confidence, system awareness, and knowledge regarding IPV service delivery. Compared to Survey 1, higher percentages of Survey 2 respondents demonstrated high confidence and high system awareness. In items testing for knowledge, Survey 2 respondents had higher percentages of accurate responses for all but two of the items tested. All items testing for confidence had at least a 20% increase in the percentage of participants who reported high confidence. The highest increases were noted for home visitors in their level of preparedness to serve families affected by IPV (% difference=41.9); their confidence in knowing how to act when a client discloses IPV experience (% difference=32.8); their confidence in screening participants for IPV (% difference=27.7); their awareness of the name of a staff person at the local domestic violence center who they could reach out to for help (% difference=43.0); and knowledge on notifying an IPV survivor prior to making a child abuse report (% difference=30.9). There was a decrease in the percent of accurate responses for survey items "I don't understand why anyone would stay in an abusive relationship" and "A problem with anger is the primary cause of IPV." All other knowledge items had increased percentage of accurate responses ranging from 4.4% to 30.9% (see Table 6).

A similar general increase in confidence, system awareness and knowledge regarding IPV service delivery albeit minimal, in comparing survey 3 to survey 2. A slight increase in percentage of home visitors demonstrated higher levels of confidence except for item "I feel prepared to serve families affected by IPV". A 0.8% decrease was observed therein and aside which increase in levels of confidence items were all less than 11%, the highest being confidence in talking to participants about red flags observed (10.5%). All items testing system awareness had at least eleven percent increase over those demonstrated in survey 2. The most improvement in high levels of system awareness was observed in being familiar with the legal options (both criminal and civil) for survivors of IPV (35.9% increase). A variety of percent difference in items measuring knowledge was demonstrated ranging from no increase to less than 20% increase. The highest increase was observed in knowledge of understanding why anyone would stay in an abusive relationship (percentage difference: 17.9); Couples counseling as an effective strategy for stopping IPV in families (percentage difference: 16.9); and "A problem with anger is the primary cause of IPV" (percentage difference: 16.7). A decrease in percent of accurate responses for knowledge items "I only refer to the local DV center if the participant wants to leave the relationship", "If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline" and "If the participant chooses to stay in an abusive relationship, there is nothing I can do". All other knowledge items responses ranged from 3% to 4% in percent increase.

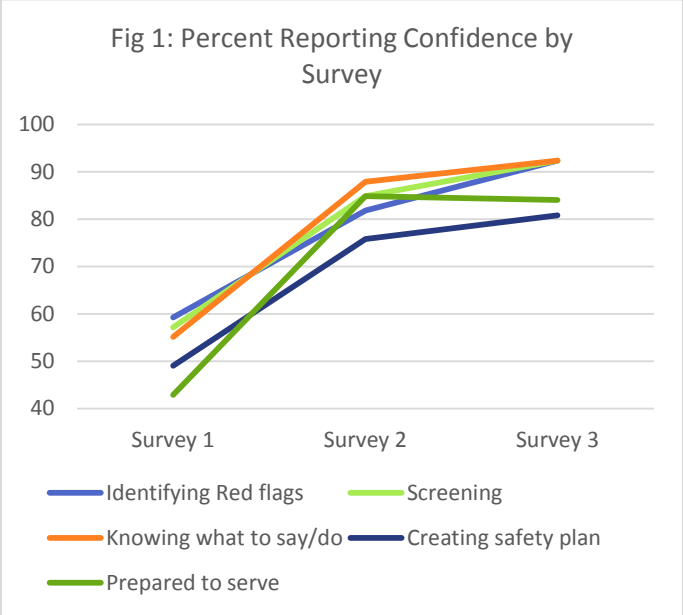
Not contrary to expectations, a higher percentage increase in confidence, system awareness and knowledge of IPV service delivery was observed when survey 3 responses were compared to survey 1. All confidence items increased in percent difference ranging between 33% and 41%. Overall, the best increase in percent difference between surveys 3 and 1 was observed in items measuring system awareness: "I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant" (57.2%) and "I am familiar with the legal options (both criminal and civil) for survivors of IPV" (48.8%).

Additionally, an increase on items measuring knowledge was observed, with similar small increases (2-3% difference) for items "If the participant chooses to stay in an abusive relationship, there is nothing I can do", "The primary cause of most IPV is alcohol or drug abuse" and "If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline". The highest difference in percent of accurate responses is 34.8% for item "Couples counseling is an effective strategy for stopping IPV in families" and 28.2% for "If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline".

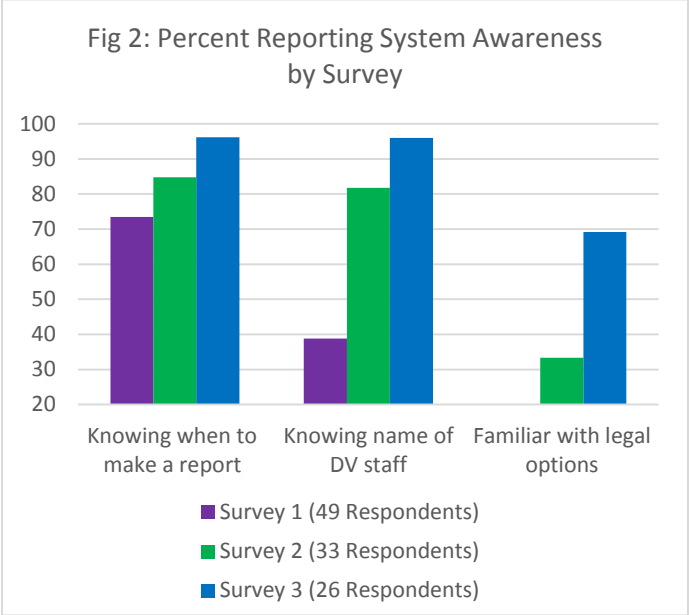
**Table 6. Home visitors' confidence, system awareness, and knowledge of IPV service delivery at baseline and after the second and third learning session**

| | High levels of confidence, system awareness, and knowledge Indicated Agree/Strongly Agree (%) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Pre-test Baseline N=49 | | Post-test Survey 2 N=33 | | Post-test Survey 3 N=26 | | Change Survey 2-1 | Change Survey 3-2 | Change Survey 3-1 |
| | % | n | % | n | % | n | % | % | % |
| **Confidence** | **Indicated Agree/Strongly Agree (%)** | | | | | | | | |
| I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship | 59.2 | 29 | 81.8 | 27 | 92.3 | 24 | 22.6 | 10.5 | 33.1 |
| I feel confident screening participants for IPV | 57.1 | 28 | 84.8 | 28 | 92.3 | 24 | 27.7 | 7.5 | 35.2 |
| When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do | 55.1 | 27 | 87.9 | 29 | 92.3 | 24 | 32.8 | 4.4 | 37.2 |
| I feel confident creating a safety plan with participants that disclose IPV | 49.0 | 24 | 75.8 | 25 | 80.8 | 21 | 26.8 | 5.0 | 31.8 |
| I feel prepared to serve families affected by IPV | 42.9 | 21 | 84.8 | 28 | 84.0 | 21 | 41.9 | -0.8 | 41.1 |
| TOTAL | 52.6 | 129/245 | 80.6 | 137/165 | 87.7 | 114/130 | | | |
| **System awareness** | **Indicated Agree/Strongly Agree (%)** | | | | | | | | |
| I know when to make a report to the child abuse hotline for IPV | 73.5 | 36 | 84.8 | 28 | 96.2 | 25 | 11.3 | 11.4 | 22.7 |
| I know the name of a staff person at our local domestic violence center that I could call if I had a question or needed assistance for a participant | 38.8 | 19 | 81.8 | 27 | 96.0 | 24 | 43.0 | 14.2 | 57.2 |
| I am familiar with the legal options (both criminal and civil) for survivors of IPV | 20.4 | 10 | 33.3 | 11 | 69.2 | 18 | 12.9 | 35.9 | 48.8 |
| TOTAL | 44.2 | 65/ 147 | 66.7 | 66/99 | 85.9 | 67/78 | | | |
| **Knowledge** | **% who answered item correctly** | | | | | | | | |
| All IPV includes physical violence | 79.6 | 39 | 87.9 | 29 | 92.3 | 24 | 8.3 | 4.4 | 12.7 |
| I don't understand why anyone would stay in an abusive relationship | 77.6 | 38 | 66.7 | 22 | 84.6 | 22 | -10.9 | 17.9 | 7.0 |
| I only refer to the local DV center if the participant wants to leave the relationship[#] | 67.3 | 33 | 81.8 | 27 | 76.0 | 19 | 14.5 | -5.8 | 8.7 |
| If the participant chooses to stay in an abusive relationship, there is nothing I can do | 59.2 | 29 | 63.6 | 21 | 61.5 | 16 | 4.4 | -2.1 | 2.3 |
| The primary cause of most IPV is alcohol or drug abuse[#] | 46.9 | 23 | 54.5 | 18 | 56.0 | 14 | 7.6 | 1.5 | 9.1 |
| If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline | 44.9 | 22 | 75.8 | 25 | 73.1 | 19 | 30.9 | -2.7 | 28.2 |
| A problem with anger is the primary cause of IPV | 38.8 | 19 | 33.3 | 11 | 50.0 | 13 | -5.5 | 16.7 | 11.2 |
| Couples counseling is an effective strategy for stopping IPV in families | 30.6 | 15 | 48.5 | 16 | 65.4 | 17 | 17.9 | 16.9 | 34.8 |
| Anger management programs are effective in preventing the recurrence of IPV[#] | 26.5 | 13 | 33.3 | 11 | 36.0 | 9 | 6.8 | 2.7 | 9.5 |
| TOTAL | 52.4 | 231/441 | 60.6 | 180/297 | 66.2 | 153/231 | | | |

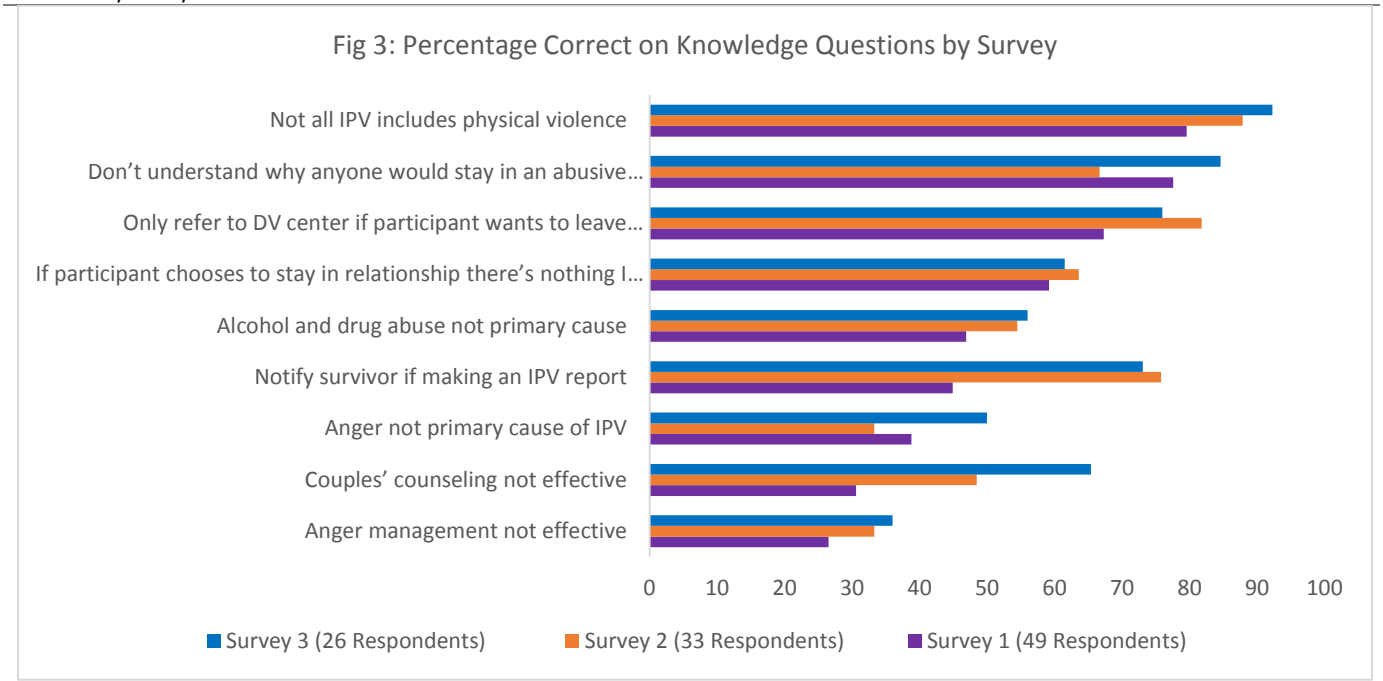
Key: [#]: Item was not answered by one home visitor




Note: Survey was distributed statewide on three occasions. Results were not individually linked, so respondents to Survey 1, Survey 2 and Survey 3 may differ.




Note: Survey was distributed statewide on three occasions. Results were not individually linked, so respondents to Survey 1, Survey 2 and Survey 3 may differ.




Note: Survey was distributed statewide on three occasions. Results were not individually linked, so respondents to Survey 1, Survey 2 and Survey 3 may differ

## Learning Sessions.

### Learning Session 1: Sarasota, FL – August 2015

### IPV Discussion Breakout Session Summary: MIECHV Supervisors and Administrators

The key themes that emerged from group discussions with MIECHV supervisors and administrators at the first learning session were related to self-care, reflective supervision, and definition of success.

#### Self-care

The MIECHV supervisors and administrators during their breakout session discussed self-care; the meaning of success, especially when working with families who may be in denial; how to initiate trusting relationships with families; and support for home visitors working with such families recognizing that this can be a source of stress. Different ways in which they performed self-care was discussed, including getting feedback and guidance, as well as using available resources. Ultimately, it was discussed that adequate self-care increases the ability of the administrator/supervisor to provide optimal support for members of the staff.

> *"…taking care of yourself will allow you to support the staff – and encouraging them to take care of themselves as well because again, this can be draining."*

#### Reflective supervision

To provide support for home visitors, the value of reflective supervision was discussed. Participants also discussed a need for increased knowledge in knowing what to do for home visitors who had experienced trauma themselves. Being a source of encouragement and helping home visitors realize their limitations in providing help was also discussed as one of the ways to provide support. Supervisors/administrators expressed their need for support, and some of them described instances where they have actively taken steps to understand the information being provided recognizing that it is necessary so they can relay information to the staff. Recognizing that added responsibility can be a challenge for home visiting staff, the group talked about how supervisors can be a source of support as program changes are being implemented. These included modeling a positive attitude with the aim of encouraging staff to adopt this positive attitude, implementing changes in small doses to increase buy-in, making it fun, encouraging everyone to participate, and celebrating successes.

> *"So you want to make it fun in a way. Change is difficult, so maybe think of different team building activities that you can do during meetings and just make it – kind of lessen the pain a little bit."*

> *"Now we're at the point where we're doing well, but we recognize that we really need to really celebrate any little thing – when we have an accomplishment because I think so many times, we're just 'Do this, do that. These screens were not completed. We don't have enough clients.' And, just step back and say, we really are moving in a very good direction and we celebrate any accomplishment or when they've done a good job, because they really do great things every day."*

> *"We worked really small tests, and we had some really big improvements. It was all because of the work that they did. They were recognized for that."*

#### Definition of success

It was decided that **success cannot be measured based on eliciting disclosure/positive screens or how many women use the resources and education given to them**. Success was, however, defined as home visitors being able to recognize red flags and respond with appropriate referrals and having the client comfortable with her decision and choice. The co-facilitator defined success as the home visitor providing information and offering services. While it is important to respect the decisions of the participants, they may or may not feel comfortable

with their decisions because of what is at stake. Due to the concern for safety, the decisions may change as the circumstances change. The important piece is that the home visitor has provided resources so that the participants can make informed decisions. The role of the supervisor is to help coach their staff in recognizing IPV and supporting survivors. They must help their staff to become aware of their own biases, in an effort to eliminate judgment.

> *"I think for me, success is when the woman or participant or client is feeling comfortable and confident with her decision and her choice."*

## IPV Discussion Breakout Session Summary: MIECHV Home Visitors

During the home visitors' focus group breakout session, they discussed multiple aspects of the learning session that they believed were thought-provoking. Several aspects of competently serving families experiencing IPV were discussed including education, screening tools, screening strategies and increased awareness of IPV among staff and program participants were discussed.

### Lack of knowledge

Several home visitors stated that education was an important aspect that needed to be implemented for both home visitors and clients. With varying levels of experience and differing educational, as well as occupational, backgrounds, some of the home visitors reported very little understanding of how to appropriately convey the impact violence in the home has on children. A few home visitors discussed the lack of resources/help for children who grow up in homes where IPV occurs and expressed an interest in further training to learn more about this. Overall, when asked by the moderator to share their experiences and thoughts following the first day of the learning session, the home visitors shared their experiences in personally experiencing IPV and being witness to IPV. They also voiced a desire for more training as it relates to their education and the education of their families, as well as ways to help participants to disclose and seek help. One home visitor stated training in motivational interviewing and other strategies was helpful. Additionally, the moderator suggested that training on adverse childhood experiences will help increase knowledge of the impact of children's exposure to violence and home visitors agreed with her that this is a priority area.

> *"Mostly with domestic violence, they focus so much on the mom that they forget that their children have to live with it long term because as they grow into adulthood... The trauma is still in you. It never goes away."*

Home visitors believed that the main reason mothers stayed in an abusive relationship was they felt it was important for their child to have a father. Home visitors also stated that appropriately educating women on resources, as well as impact of violence on themselves and the children witnessing the violence would lead to women leaving the relationships. One home visitor stated a participant had already "denied" experiencing IPV, however, on receiving information about the negative impact IPV on children, she left her partner.

> *"I ended up [sic] the relationship with him right away after I heard you saying how much it affects our children, and I've been in this domestic violence relationship for a long time. I'm sorry I lied to you."*

### Curriculum

To resolve the issue of lack of knowledge on both the part of some of the home visitors and the participants, a suggestion was made that a curriculum be developed or acquired that appropriately addressed healthy and unhealthy relationships, not just IPV, and appropriate resources to provide to participants and their children. This curriculum would permit the conversation to occur in a less startling manner and afford the home visitor the opportunity to address the topic in a sensitive and appropriate manner.

> *"We need curriculum that we can address these issues before that even happens... None of our curriculum addressed that. I could simply go back and talk about how does arguing affect your children? What if this*

*happened? If we have some curriculum to go by, to start doing this before we even do the heart because we're already talking about it. That may open them up, disclosing something earlier than we have to wait for six months or close. It may open it up right away and we can get them services right away before the child is dangled over something like that. We don't have curriculums. We have handouts. I mean we have little booklets that we could go in but now I got to figure out how I'm going to get away with this if it was the service plan. We have the service plan. We have that on the service plan, but we really don't have the curriculum at the outside. We've been looking for it, I called and asked for those little booklets, how domestic violence affects families but we have to know how to open that up. If I had an easy curriculum that I could introduce to this family before it gets there, it would make it a lot easier."*

### Screening tools

The home visitors expressed concern about how the screening tools for IPV may not necessarily be most sensitive to detecting families who have experienced IPV. Some home visitors felt that the stark and "aggressive" nature of the questions, along with the fact the questions so clearly are trying to assess for violence in the home, make it awkward to address within the first few months of interacting with the family. There was also a feeling that participants are unlikely to disclose such personal information. Two approaches were discussed that other sites use to lessen the intensity of asking such sensitive questions. The first suggestion was ensuring that a rapport was developed between the home visitor and mother. This home visitor stated she was able to establish rapport because she saw her families on a weekly basis for the first few months and assured that these questions were asked of every family. One home visitor agreed that rapport was important, but that waiting longer to complete the measure could be a viable option if frequency of visits was less than once a week. Another suggestion made to help with the issue of the required screeners was incorporating the questions into a conversation as opposed to engaging in an interaction that comes off "robotic" and unnatural. Some home visitors said that they were able to do that because of training they received at their respective sites. Others stated they were fearful of not completing every question if they did try to make the questions flow in a conversation as they had not been granted permission, or been provided the training, to do so by their program.

*"We need to stop focusing so much on the form and give more, be more human, and be more empathetic."*

### Agency and program factors

As many of the MIECHV programs occur in various agencies, different requirements exist in addition to those required by MIECHV and the program that is being implemented (i.e., PAT, NFP, Healthy Families). Many home visitors felt frustrated that the agency in which they were housed required they attend meetings they felt were irrelevant or interrupted time with their families. One session participant stated that her colleague missed out on a whole day of work due to meetings and still had to meet with her 25 families within her remaining 30-hour work week. Another point specific to systems navigation was aiding immigrant and undocumented families because leaving a violent partner would lead to social isolation and with no control of whether the participant could stay in the US after leaving said partner. No suggestions were made on how to deal with this particular concern during the learning session, but staff were later provided with online training that addressed it.

## Learning Session 2: Kissimmee, FL – November 2015

### IPV Discussion Breakout Session Summary: MIECHV Supervisors and Administrators

The breakout session was specifically targeted at situations where home visitors experience trauma (direct or secondary traumatic stress) – especially relating to IPV – and how supervisors/administrators best support them. They also discussed measures for keeping home visitors safe in that situation and policy level ways in which to address it. The topics that were discussed at this breakout session related to reflection supervision and workplace violence.

### Reflective supervision

The first point touched on reflective supervision and how that helps in their supervisory roles. This was referred to as self-care by one of the DV advocates. Supervisors talked about how they utilize reflective supervision. Themes that emerged in terms of effectiveness of reflective supervision included timing and content. In terms of timing, two participants explained that they had weekly meetings with team members to talk about what goes on in the field. In addition to these meetings, there were also some random check-ins with team members to ensure everything was going well. The content of these supervisory efforts were mostly similar. It included being supportive - with their experiences in the field, their emotions and feelings about these experiences and with their caseloads.

> *"We're just doing a lot of constant checking with that person just to make sure that they're okay with what's – with working with this family, that it's not bringing something up for them, and that's difficult for them to work through."*

### Workplace violence

The group discussed specific policies that were in place with respect to dealing with workplace violence and disclosures of IPV by their staff/team members. There did not seem to be any specific policies or guidelines for these situations. One participant commented that new policies are only written when a particular situation occurs. Strategies discussed on this topic were: 1) referral to the Employee Assistance Programs for staff members; 2) a personal policy to be non-intrusive and supportive; 3) referral to the home visiting program's mental health specialists; and 4) providing resources for additional help. A participant shared a story about how IPV experience by a team member threatened not just her but also her coworkers, including instances where the perpetrator called and came to the workplace. These incidents led to the development of safety policies for their agency.

> *"You're only writing policies when you get into that situation."*

The group went on to discuss some practical things that can be done by supervisors to help in identifying and addressing instances of workplace violence. These included paying attention, documentation, looking to social workers as sources of information, making appropriate referrals based on issue (mental health, IPV), building a relationship with local DV centers, and educating staff members. One group member described a mandatory workplace training that they receive from a staff member at a DV shelter. A challenge to the issue of addressing workplace violence that emerged was the prevailing assumption that it doesn't occur. Furthermore, the group discussed strategies to increase workplace safety such as checking ID cards of employees. Staying safe while out visiting families was another issue that emerged; a potential solution was taking different routes to get to families' homes.

> *"Because I think it's still this perception that it only happens to these certain types of women."*

> *"I don't know if [the presenter] said this or not, but that is what stood up in court. It was even more important to her case than the video itself. It was the documentation of her supervisor because that showed that it wasn't just a single event. She had documentation for over a year, and so that showed that this abuse was happening consistently, so it's something as simple as keeping a calendar."*

## IPV Discussion Breakout Session Summary: MIECHV Home Visitors

The session with the home visitors was primarily a reflective session. It focused on self-care and techniques to relax and cope with stress. Participants were taught several methods of coping with stress (breathing techniques and mindfulness techniques) and also had the opportunity to practice some of the techniques within the group.

The session began by asking home visitors to mention a self-care act that they had used in the past week. Self-care techniques that emerged from the conversations included:

1. Not answering or turning off their phone,
2. Watching their favorite shows on TV or on Netflix (a lot of people used this strategy),
3. Reading,
4. Cutting down or refraining from work during travel or leaving work at work,
5. Taking time off to rest and relax,
6. Listening to music (a lot of people also use this strategy),
7. Going to bed early or getting more sleep in general
8. Catching up on couponing,
9. Talking to a supportive person such as their mother or grandmother,
10. Praying,
11. Establishing boundaries as a preventive approach so they do not need emergency self-care,
12. Painting nails, and
13. Staying at work to escape going back to a stressful home environment.

> *"One of the things I established a long time ago is boundaries. So I find that the self-care I don't need as much, or it's not as an emergency as it used to be. When I leave work, I leave work and I turn everything off so that I can just focus on the rest of my life."*

Following this, the group facilitators discussed the need to identify specific triggers related to IPV. The group considered physical, cognitive, and behavioral cues. Triggers could be as a result of a personal experience, knowing someone that has had the experience or working in that situation (compassion fatigue). Other things that could affect one's perspective of IPV included background experience, beliefs (cultural, religious, etc.).

> *"Cultural beliefs, religious beliefs that may influence how you see intimate partner violence when you're in a home... what clues will tell you, 'Is my perspective influencing my reaction to this situation?'"*

To round up the session, group facilitators discussed specific coping mechanisms with the group. Specific coping strategies included:

1. Movement for at least 10, 15, or 20 minutes per day,
2. Having evening sleep routines (e.g. reading before bed),
3. Slow, deep, rhythmic breathing,
4. Mindful thinking, which improves mental, psychological, emotional, and physical health,
5. Enjoyment of pleasant activities,
6. Writing down string of consciousness, and
7. Setting aside time to think about the things you can't just let go of.

> *"Exercise. Now, this immediately brings guilt to everybody's mind. Right? You don't have to join a gym, you don't have to get one of those fancy Fitbits. You don't have to buy any kind of special shoes. Just move; for at least 10, 15, ideally 20 minutes a day. Walk your dog. I always turn on dance songs. I just love to dance. Not only am I moving my body but I'm in a very happy place."*

> *"It's always good to have some kind of bedtime routine, right? We do that with our kids. It's like bath, book, bed. But we don't do it ourselves. Part of a routine tells our body, "Okay, it's time to disconnect and go to sleep."*

## Learning Session 3: Jacksonville, FL – March 2016

### Focus Groups 1 and 2 Summary

The focus group discussion specifically aimed to receive feedback from attendees about the learning collaborative (LC). This discussion covered topics on the successes and challenges of the LC, personal impact that the LC has had on them, strategies used for information sharing during the LC, strategies for sustainability and the next steps. Focus group attendees felt that having the guest speakers during the learning sessions was one of the things that went well for the LC. The personal stories shared by the guest speakers helped them to identify victimization and also be more aware of clients. Another thing that went well was the information shared during the guest presentations. This information built from personal to factual and participants felt that this was useful. Other areas of success included the provision of visual tools on how to appropriately complete necessary programmatic paperwork and training in quantitative data to help program staff understand whether their anecdotal data matched their numbers.

> *"It is personal, I mean we're not trying to make them dredge up their trauma, but it really does – it does give you insight. You get to ask them questions and you get to remember why you do this kind of work, why you're getting all up in the trauma. "*

Attendees also discussed the personal impact the collaborative had on them including increased passion and likelihood of advocating for DV screening after establishment of trust with their clients. Other positive impacts included being better able to address data entry and minimize missing data, increased ability to connect with groups/service providers because of information received during the sessions and a positive impact on how data is reviewed at their respective sites.

When discussing challenges with the Learning Collaborative, attendees said that the message they received didn't seem customized for their program, the sessions did not have enough in them for data entry specialists and that there was miscommunication regarding usage of the cards ['Healthy Mom, Healthy Babies' cards]. Other challenges that were mentioned includes paperwork, an overwhelming number of sessions, trying to figure out if to prioritize testing or the task at hand, as well as a lack of clarity on what to be doing at each point in time. Some members of the group suggested that it would be more beneficial to space out the learning sessions and have more practical activities during the sessions.

> *"I think she brought in a lot of informative material and it was helpful like some things that I wanted to include into my policy but I think they were too general, maybe specific for those particular states that she was in and not customized for our state so that's why it was like, "Okay. This was great, but we don't - we want you to take that information, but don't spread that… so I can kind of see why it would feel like it was, what was the point…"*

Furthermore, participants discussed the strategies the travel team had used in sharing information with other members of the team. These strategies included having team meetings to share the stories and information received, discussions as to how to tailor the implementation to fit the team's particular needs, and voting on which methods to use. However, buy-in was said to be a challenge when the information was brought back to team members. Participants also felt that there was a disconnect with regards to information delivery when bringing back information to the rest of the team. A suggestion for a possible solution to this disconnect was that the sessions should be recorded or video-taped if possible.

> *"So I don't know how you would fix something like that. I mean, maybe some short clips. I know we got the videos, a couple DVDs, maybe when the speakers are here, since they do small stuff like an hour, an hour and a half, some of that might, could be recorded and then we could play it by team meetings and maybe we'd get their passion going a little bit more."*

> *"We shared the story about what happened during a learning collaborative and what we would like to focus on for the next step and how to go about doing it, like as a democracy rather me coming and this is a policy*

*that we follow, getting feedback like I have a couple of policies, let's look at them and try to merge them into something that would work for us so that way they can buy into what we wanted them to do rather than the CQI team coming in and saying, "Okay. This is what we're going to do now. This is what you should do."*

Other suggestions on how to improve sharing of information with other team members were rotating staff participation in the learning sessions, including information/teaching on how to construct the Plan-Do-Study-Act (PDSA) cycle, clarifying procedures, including information on how to present effectively and possibly increasing the time allotment for presentations.

To promote sustainability of lessons learned from the CQI effort, participants said that they put the lessons into a policy. The specific steps they have taken towards sustainability includes steps with the domestic violence centers such as training of call procedure, training the domestic violence staff about the MIECHV program to have a referral program collaboration, and a breastfeeding workshop to create partnerships. To promote their skills with interacting with domestic violence clients, focus group attendees discussed annual training of new hires to orient them to proper procedures, guidelines and services in addition to more in-depth orientation for existing and new staff on domestic violence clients. Attendees also shared that it will be supportive of their work if the MIECHV CQI staff/IPV faculty can advocate for a better screening tool as well as tools for safety planning.

*We have annual training for ladies but then and the DV shelters are going to do the training for us. Then, we're doing the – every other year, we'll do a refresher for the sessions, again, through the DV shelters.*

Next steps were discussed that included taking things "step by step" and building on new changes, developing a process for change flexibility of going back to make changes, continued testing to revamp change/approach, demonstration of success to increase buy-in ("proof in pudding", getting ideas from different groups/people and ensuring sustainability. At the end of the session, respondents talked about their appreciation of all the efforts that had been put into the learning collaborative sessions and in providing support to the individual Florida MIECHV programs and staff. One participant said that the introduction of MIECHV into Florida has provided staff with the appropriate quality training that had not existed prior and that the "face of home visiting" has changed for the better.

**Table 7: Intimate Partner Violence (IPV) Measures**

| Measure # | Performance Goal | Measure Name/ Operational Definition | Data Collection Plan | Rationale |
|---|---|---|---|---|
| 1. | By May 31, 2016, at least 90% of women will be screened with an appropriate IPV screening instrument within six months of program enrollment. | % Women Screened with 6 Months of Enrollment<br>Process Measure: # of women screened for IPV within 6 months of enrollment/# women enrolled at least six months and women screened prior to six months | Data collected by: Home visitors<br>Data source: Participants, direct assessment<br>Frequency of data collection: within 6 months of enrollment and as needed<br>Data point: 6 months post-enrollment | All women should be screened for IPV as soon as is appropriate, but no later than six months after enrollment. Unless there are immediate indicators, taking time to develop trust prior to screening is often helpful. A screen should be conducted immediately, if there are indicators of IPV. |
| 2. | By May 31, 2016, at least 85% of women will have a safety plan in progress within 30 days of screening positive or disclosing IPV. | % of eligible women who have safety plan within 30 days of identification<br>Process Measure: # of women who have a safety plan within 30 days of positive screen or disclosure / # women with positive screen or disclosure | Data collected by: Home visitors<br>Data source: Program documentation<br>Frequency of data collection: ongoing<br>Data point: 30 days after positive screen or disclosure | The home visitor must determine what safety planning is needed. Ideally, a DV advocate will take the lead on safety planning, but a trained home visitor should do basic safety planning with participants, if the woman chooses not to speak with a DV advocate. |
| 3. | 3. By May 31, 2016, at least | % women referred w/in 7 | Data collected by: Home | Once a woman screens |

| | | | | |
|---|---|---|---|---|
| | 85% of women will have been referred to a certified DV center or other appropriate IPV service within 7 days of screening positive for IPV or disclosing IPV (if not already receiving appropriate services). | days<br>Process measure: # of women who were referred for IPV services within 7 days of positive screen or disclosure/ # women with positive screen or disclosure | visitors<br>Data source: Program documentation<br>Frequency of data collection: ongoing<br>Data point: 7 days after positive screen or disclosure | positive or discloses IPV, a referral to appropriate services should be made as quickly as possible-within 7 days at the latest-to minimize the risk of harm and infuse supports as soon as possible. |
| 4. | By May 31, 2016, the # of monthly home visits will remain consistent. | Workload Management<br>Balancing measure: Total number of home visits | Data collected by: Home visitors<br>Data source: Program documentation<br>Frequency of data collection:<br>ongoing<br>Data point: At time of monthly report | Participation in the Learning Collaborative could inadvertently affect the ability to complete home visits. |
| 5. | By May 31, 2016, home visitors will report an increase in IPV knowledge from 52 percent at baseline to 75 percent, as measured by the IPV survey. | % of home visitors demonstrating increased IPV knowledge<br>Outcome measure: % of home visitors who demonstrate increased knowledge about IPV | Data collected by: MIECHV evaluator<br>Data source: Survey of home visitors<br>Data points: Prior to first learning session, at the mid-point and at the end | Home visitors who are knowledgeable about IPV will provide better services, including screening, referrals and safety planning. |
| 6. | By May 31, 2016, home visitors will report an increase in system awareness from 44 percent at baseline to 75 percent, as measured by the IPV survey. | % of home visitors demonstrating increased IPV system awareness<br>Outcome measure: % of home visitors who demonstrate increased knowledge about IPV | Data collected by: MIECHV evaluator<br>Data source: Survey of home visitors<br>Data points: Prior to first learning session, at the mid-point and at the end | Home visitors who are aware of systems to support IPV survivors will provide better services, including screening, referrals and safety planning. |
| 7. | By May 31, 2016, home visitors will report an increase in confidence when supporting families experiencing IPV from 53 percent at baseline to 75 percent, as measured by the IPV survey. | % of home visitors demonstrating increased confidence<br>Outcome measure: % of home visitors and who self-report increased confidence supporting families experiencing IPV total # of home visitors | Data collected by: MIECHV evaluator<br>Data source: Survey of home visitors<br>Data points: Prior to first learning session, at the mid-point and at the end | Home visitors who are confident supporting families experiencing IPV will provide better services, including screening, referrals and safety planning. |

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