Improving the Quality of Home Visitors' Screening and Support for Mothers Experiencing Intimate Partner Violence in the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

Jennifer Marshall[1], Pamela Birriel[1], Ngozichukwuka Agu[1], Judi Vitucci[2], Allison Parish[2], and Carol Brady[2]

[1]University of South Florida, College of Public Health, Chiles Center for Healthy Mothers and Babies; [2]Florida Association of Healthy Start Coalitions, MIECHV Program

Background

- Intimate partner violence (IPV) is a silent epidemic.
- Nearly 1 in 3 women and 1 in 4 men have been physically harmed by an intimate partner; unfortunately, children are often witnesses to the violence.[1]
- **According to the National Survey of Children's Exposure to Violence[2]:**

Within the previous 12 months: "1 in 15 children were exposed to IPV between parents (or between a parent and that parent's partner)."[2]

"During their lifetimes, 1 in 4 were exposed to at least one form of family violence."[2]

"Of the children exposed to IPV, 90% saw the violence, as opposed to hearing it or other indirect forms of exposure."[2]

When IPV occurs, there may be detrimental physical and mental health effects on women, infants, and young children (the primary population served by home visiting programs).

Women who experienced IPV in the year prior to pregnancy were at increased risk for preterm labor. Additionally, their infants were at greater risk of having a low birth weight and requiring intensive care compared to women that did not experience IPV during that time.[3]

Preterm labor and other pregnancy complications are greater for women experiencing IPV during pregnancy, when compared with women that did not experience IPV, even when they did not experience IPV prior to pregnancy.[3]

Violence during pregnancy and the postpartum period has been linked to elevated levels of various emotional health problems, including depression, anxiety, Posttraumatic Stress Disorder (PTSD), and other forms of psychological distress.[4]

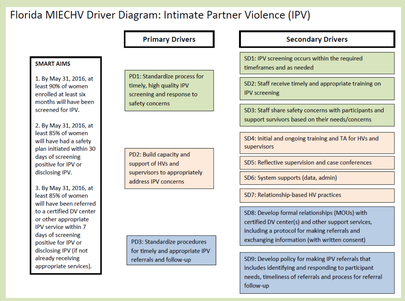
Infants who hear or see unresolved angry conflict or witness a parent being hurt may show symptoms of PTSD, including eating problems, sleep disturbances, lack of typical responses to adults, and loss of previously acquired developmental skills.[5]

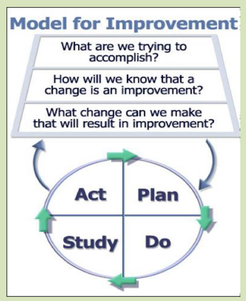
Significance

- Evidence suggests that incorporating comprehensive IPV prevention, screening, and intervention (connections with appropriate supports) into home visiting programs can help improve the trajectory for families experiencing IPV.
- Few programs provide the training and professional development necessary for home visitors to feel confident and knowledgeable in the services they provide for women experiencing IPV.

Purpose

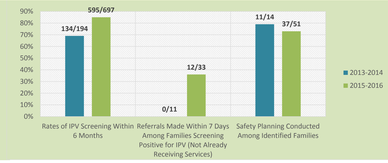
- Home visitors in the Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program offer support to over 1,500 families, including those who are experiencing IPV and those that are at-risk.
- The Florida MIECHV Continuous Quality Improvement (CQI) team determined that a more comprehensive approach to addressing IPV was needed.
- To improve IPV screening, client support, and referral in the Florida MIECHV program, a Learning Collaborative of 8 program sites launched a 10-month statewide CQI effort.





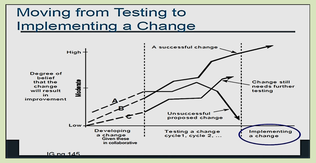
IPV Screening

- At the start of the Learning Collaborative, there had been wide variation in IPV screening and follow-up practices across Florida's MIECHV sites.
- To improve these rates, the Learning Collaborative facilitated by the Florida MIECHV initiative was modeled after the Institute for Healthcare Improvement's Breakthrough Series (www.IHI.org).[6]



Methodology

- The mission of this 10-month Learning Collaborative (August, 2015 through May, 2016) was for 8 local implementing agencies (LIAs) to test best practices from a change package that will lead to a significant improvement in:
  - Screening women for IPV
  - Staff having the knowledge and confidence to effectively support families that are experiencing IPV through appropriate referrals and safety planning
- The LIAs participated in 3 in-person Learning Sessions and monthly webinars, as well as conducted and submitted:
  - PDSA (Plan, Do, Study, Act) testing
  - Data on screening, referrals, and safety planning



Training Topics	
✓ Rapid cycle testing	✓ Female to Male Violence
✓ Screening and continuous quality improvement	✓ Responding to domestic violence in the African-American community
✓ Best Practices for Screening, Identification & Responding to IPV	✓ IPV among Latinos
✓ Effects of IPV on children	✓ Working with Hispanic survivors

Evaluation Component

- An anonymous pre- and post- survey was disseminated to assess overall home visitor knowledge of IPV, confidence in addressing IPV in their clients, and knowledge of IPV-related systems and resources.
- Quantitative data was collected through an email link to the Qualtrics online survey distributed to all Florida MIECHV home visitors.
  - Survey data was downloaded to SPSS v.22 and descriptive analysis was conducted to determine knowledge, confidence levels, and system awareness of home visitors.
- Simultaneous, semi-structured group discussions that took place during the 3 Learning Collaborative sessions generated qualitative data.
  - These discussions were audio recorded, transcribed, and thematic analysis was performed

"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 Visitor

Results

Results from Group Discussions at Learning Collaborative Study Sessions

Learning Session 1: Administrators/Supervisors discussed how to be successful in this effort and their role in supporting staff, particularly when working with families who may be in denial or choose not to disclose; how and what it means to initiate that trusting relationship, redefining success. Home Visitors discussed aspects of the learning session that were thought-provoking, including the need for more education, better screening tools and strategies, and improving awareness of IPV among staff and program participants. Another issue discussed was the impact of IPV on children.

Learning Session 2: Administrators/Supervisors discussed the need for policies regarding workplace violence, the impact of IPV on staff, and safety in home visiting environments. Also discussed was the importance of supporting staff through reflective supervision and organizational supports (EAP, mental health specialists, or other resources); non-intrusive, yet supportive approach; and awareness and documentation of IPV in the workplace. Home Visitors discussed self-care and stress management, including a workshop learning stress-management techniques. Participants described a number of strategies they use to manage work-related stress and also discussed personal triggers related to IPV based on previous experience or background.

Learning Session 3: Both groups discussed successes and challenges of the Learning Collaborative, as well as the impact that the Learning Collaborative has had on participants, such as an increased passion and likelihood to advocate for domestic violence screening in their clients after trust had been established. Additionally, strategies, challenges, and suggestions for improvement were discussed regarding information sharing during the Learning Collaborative. Lastly, strategies for sustainability and next steps, such as implementing the lessons into a policy and specific steps taken with local domestic violence centers were shared.

Results

- PDSA data from the first quarter of the CQI effort show that from September through December 2015, 91% (138/151) of newly enrolled families received IPV screening within 6 months; 91% (21/23) of families identified with IPV received referral to services; and 95% (20/21) of identified families received safety planning within 30 days.
- There was a general increase in confidence, system awareness, and knowledge regarding IPV service delivery.
- All survey items for confidence levels and system awareness received higher results in the post-survey; however, there was a decrease in the percent of accurate responses for two of the items testing for knowledge
- Highest differences were noted for home visitors in their:
  - Knowing the name of a staff person at the local domestic violence center who they could reach out to for help (% difference=43.0)
  - Level of preparedness to serve families affected by IPV (% difference=41.9)
  - Confidence in knowing what to say or do when a participant discloses that he/she has experienced IPV, (% difference=32.8)
  - If possible, would always notify the IPV survivor prior to making a report to the child abuse hotline (% difference=30.9)
  - Confidence in screening participants for IPV (% difference=27.7)

Pre-Post Survey Comparison

	Survey 1 High Confidence, System Awareness, Knowledge		Survey 2 High Confidence, System Awareness, Knowledge		Difference (Post-Pre)
	%	n	%	n	%
Confidence					
I feel confident talking to participants about red flags I have observed that may indicate an unhealthy relationship	59.2	29.0	81.8	27.0	22.6
I feel confident screening participants for IPV	57.1	28.0	84.8	28.0	27.7
When a participant tells me he/she has experienced IPV, I feel confident that I know what to say or do	55.1	27.0	87.9	29.0	32.8
I feel comfortable creating a safety plan with participants that disclose IPV	49.0	24.0	75.8	25.0	26.8
I feel prepared to serve families affected by IPV	42.9	21.0	84.8	28.0	41.9
System Awareness					
I know when to make a report to the child abuse hotline for IPV	73.5	36.0	84.8	28.0	11.3
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	19.0	81.8	27.0	43.0
I am familiar with the legal options (both criminal and civil) for survivors of IPV	20.4	10.0	33.3	11.0	12.9
Knowledge					
All IPV includes physical violence	79.6	39.0	87.9	29.0	8.3
I don't understand why anyone would stay in an abusive relationship	77.6	38.0	66.7	22.0	-10.9
I only refer to the local DV center if the participant wants to leave the relationship	67.3	33.0	81.8	27.0	14.5
If the participant chooses to stay in an abusive relationship, there is nothing I can do	59.2	29.0	63.6	21.0	4.4
The primary cause of most IPV is alcohol or drug abuse	46.9	23.0	54.5	18.0	7.6
If possible, I would always notify the IPV survivor prior to making a report to the child abuse hotline	44.9	22.0	75.8	25.0	30.9
A problem with anger is the primary cause of IPV	38.8	19.0	33.3	11.0	-5.5
Couples counseling is an effective strategy for stopping IPV in families	30.6	15.0	48.5	16.0	17.9
Anger management programs are effective in preventing the recurrence of IPV	26.5	13.0	33.3	11.0	6.8

Conclusion

- Overall, this CQI project was a success. Rates of screening, safety planning, and referrals increased; home visitor knowledge, confidence, and system knowledge increased; and participants gained CQI skills and successfully implemented several PDSA cycles.
- Programs will continue to develop and implement policies, procedures and strategies to improve IPV screening, support, and referral services using the knowledge and skills gained through this project.
- Additional trainings will be offered through the state MIECHV initiative, including those to address items on the questionnaire, training on legal aspects of IPV, and IPV screening, assessment, and support tools.

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

"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…"

USF HEALTH
COLLEGE OF PUBLIC HEALTH
UNIVERSITY OF SOUTH FLORIDA

Email: jmarshal@health.usf.edu

References

[1]U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2010). *National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*. Available at: http://www.cdc.gov/violenceprevention/nisvs

[2]Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). Children's exposure to intimate partner violence and other family violence (pgs. 1-12). *Juvenile Justice Bulletin – NCJ 232272*. Washington, DC: U.S. Government Printing Office. Available at: https://www.ncjrs.gov/pdffiles1/ojjdp/232272.pdf

[3]Silverman, J., Decker, M., 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(*1*):140-8.

[4]Martin, S., Arcara, J., & Pollock, M. (2012). Domestic violence during pregnancy and the postpartum period. Harrisburg, PA: National Resource Center on Domestic Violence. Available at: http://vawnet.org/applied-research-papers/

[5]Carpenter, G. & Stacks, A. (2009). Developmental effects of exposure to Intimate Partner Violence in early childhood: A review of the literature. *Children and Youth Services Review*; 31: 831-839.

[6]Institute for Healthcare Improvement. (2003). *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. Cambridge, MA.

This project is supported by:

Florida Association of Healthy Start Coalitions, Inc. — Every baby deserves a healthy start

Florida Maternal Infant & Early Childhood Home Visiting Initiative

The Lawton and Rhea Chiles Center for Healthy Mothers and Babies

Our Practice Is Our Passion