

The North Carolina Northeastern *Baby Love Plus* Program
Strengthening Systems of Care
to Address Family Violence
During and Around the Time of Pregnancy

Impact Report
April 2007

Grant Number H64 MC00025-02

NC Department of Health and Human Services
Women's and Children's Health Section
1929 Mail Service Center
Raleigh, NC 27699-1929

Judy Ruffin, Former Project Director
Belinda Pettiford, Acting Director
919-707-5699 Phone
919-870-4827 Fax
Belinda.Pettiford@ncmail.net

Baby Love Plus(BLP) Family Violence Program Team:
Jennifer Perez, *BLP* Family Violence Care Coordinator
Jerry Hankerson, *BLP* Northeastern Regional Manager
Judy Ruffin, NC *BLP* Program Director

In partnership with

Julie DeClerque, Evaluation PI UNC Sheps Center
Sandy Martin, Evaluation Co-Investigator UNC School of Public Health
Ellen Shanahan, Evaluation Project Coordinator UNC Sheps Center

1. Project Identification

Project Title: North Carolina Northeastern Baby Love Plus Program---Developing a System of Care to Address Family Violence During or Around the Time of Pregnancy

Project Number: H64 MC00025-02

Project Director: Judy Ruffin, MPA, Former Project Director
Belinda Pettiford, MPH, Acting Director
(919) 707-5699 Phone
(919) 870-4827 Fax

Grantee Organization: NC Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

Address: Location: 5601 Six Forks Road
Raleigh, NC 27609
Mailing: 1929 Mail Service Center
Raleigh, NC 27699-1929

Email: Belinda.pettiford@ncmail.net

Homepage: www.dhhs.state.nc.us/dph

Project Period: 6/01/02-5/31/06

Total Amount of Grant Awarded: \$450,000

Narrative:

I. PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD Health (MCH) Programs

A. Problem(s) Addressed

The five-county project area (Gates, Halifax, Hertford, Nash, and Northampton counties) covered some of the most economically deprived areas of the state. The perinatal health status of its female residents was reflective of a low-income population with poor birth outcomes and a high prevalence of associated risk-factors. According to the 2000 Pregnancy Risk Assessment Monitoring System (PRAMS) for NC, physical violence during pregnancy by an intimate partner was almost four times higher for African American and other minorities (18.2%) than that of Caucasians (4.6%). Almost 40% of the minority group was age 24 or younger and about 55% had a high school degree or less. Although these are statewide statistics, the age range, education level and economic picture of the project area mirrored that of the state. Considering that the five health departments located in the project area serve a largely African American and American Indian population, the state statistics indicate that a disproportionate number of women in the project area may be experiencing violence in and around the time of pregnancy.

North Carolina has put forth great effort to improve the status of women, especially around violence prevention. Action was spurred and led by the NC Council for Women in 1978. In 1991, the Domestic Violence Center Fund was enacted to provide support to local domestic violence programs and to the NC Coalition Against Domestic Violence. The legislation stipulated that to be eligible for funds, a domestic violence center must

offer: hotline services, transportation services, community education programs, daytime services, and call forwarding during the night. Currently, there are 76 family violence programs and 63 shelters serving the 100 North Carolina counties. Although some counties were well served by several programs, the service area of the project area was sparsely covered. Only three programs provide services in the five project counties. Prior to the new program, the shelters were basically designed to serve crisis situations. There was not a strong system linking screening and the provision of support and preventive services for families. This was an important area for enhancement as many families in this rural area are isolated from support services.

The number of domestic violence protective orders executed, along with the number of sworn officers available to serve these orders are two related factors that impact the existence of family violence resources in the five-county region. The number of protective orders issued in the project area is considered low, and again speaks to the need for education of women on their legal rights and training of the officers on the issuance of family violence protective orders. The sheriff department often serves the protective orders. At the writing of the original grant in 2002, the five-county project area had only 145 sworn officers serving a population of 184,819 (.78 sworn officer per 1,000 population). This shortage again emphasizes the need for continued partnership and community education around family violence.

Focus on Birth Outcomes

Historically, the NEBLP project area has recorded some of the highest infant mortality and morbidity rates in North Carolina, a state that itself experiences one of the highest rates of infant mortality in the nation. For the time frame preceding the submission of the

original grant (1996-1998), 7,668 live births occurred in the region. While these births were divided almost equally between White females (46% or 3,582 births) and African-American females (52% or 3,968 births), the risk of poor health outcomes and low utilization of health services was disproportionately high for women of color living in the project area. Over 20% of the area births were to women who entered prenatal care after the first trimester, and this proportion was more than twice as high for African-American females. Between 1996 and 1998, 1,765 (23%) of the births were premature (<37 weeks gestation), and 1,029 (13.4%) babies were born weighing 2,500 grams or less. African-American babies accounted for 69% of these low birth weight (549) babies and 62.4% of the premature births. During this same time period, 108 infant deaths occurred in the project area, for a regional rate of 14.1 compared to the state rate of 9.2. African-American infants accounted for 74% (80) of the deaths versus 25% (27) White infant deaths. Thus, African-American infants were more than 4.7 times likely to die than their White counterparts. Only one American Indian infant death occurred during this period. Gates County recorded the lowest African-American infant death rate at 9.6 (3 deaths) and Northampton County recorded the highest at 18.6. Twenty-nine infant deaths occurred in the project area in 1999 with the majority being African-American infant deaths (69%). Prematurity and low birth weight births are events that contribute significantly to infant mortality (morbidity) rates. Research now reveals that these type of birth outcomes are strongly linked to the preconceptional and interconceptional health status of the mother (e.g. diabetes, high blood pressure, chronic stress, poverty, unemployment, tobacco/substance use). More specifically, according to focus group data

collected in the context of the NEBLP, women noted that pregnancy not only created stress, but it sometimes is the trigger or catalyst for episodes of family violence.

B. Need

In light of the problem presented, NEBLP staff, Regional Consortium members, and community partners identified the needs listed below (with a brief description) as priorities.

Screening and Referral

Local health departments in the project area provided some measure of screening of their patients for physical and emotional abuse; however a **comprehensive** family violence assessment tool was high on their list of needs. Prior to the implementation of this project, the favored tool was the Maternal Care Coordination (MCC) Form which screens for health, social, and financial issues. Although the MCCs are trained social workers and registered nurses, and are skilled in interviewing techniques, the Record Form was not designed to build rapport with the client, determine the severity of the violence, identify the imminence of danger, or determine whether children were involved. Secondly, local health department prenatal record reviews showed approximately one patient per month admitting being the victim of family violence. This was in line with NC Pregnancy Risk Assessment Monitoring System (PRAMS) data showing 6% of women admitting family violence (7% nationally). Local family violence experts presume this to be a gross undercount, noting further work is needed to verify reasons for nondisclosure. It can be assumed that for every client seeking services, there is a parallel number who are silent about the physical and emotional abuse they suffer. At the writing of the original grant, collectively the three local family violence programs in the area had served 4,630 clients.

Thirdly, a great need existed for psychosocial counseling; however, none of the local health departments provided psychosocial counseling to their patients prior to this project. Individuals needing such services were referred to one of three local mental health centers in the region---Edgecombe-Nash Mental Health Center, Riverstone Counseling and Personal Development Center, or Roanoke-Chowan Human Services. While the mental health programs are somewhat responsive to the referrals from the health departments, limited resources are primarily used to serve patients that have a clinical diagnosis of mental illness. Subsequently, psychosocial counseling around family violence is not a high priority. Even when mental health (and also local family violence shelter space) is available to take family violence victims, the local health departments have not had much success in getting their clients to access services. The double-edged sword is the stigma attached to mental health counseling and public admission of family violence.

Other Needs

In this rural, economically depressed region, several crisis intervention resources are available to women. However, no functional system of care existed for victimized women that address family violence issues in a holistic way. In preliminary discussions with local providers (local health departments and crisis shelters), the following were critical areas that needed to be addressed to improve the system problems. The gaps fell into four areas: **training, service expansion, infrastructure development, and community outreach.**

C. Major Purpose(s) of the Project

Given the problem, need, and service gaps identified, the primary purpose of the FV project was to achieve community-based family violence reduction in the five-county project area through community commitment to addressing family violence, increased access to services and resources, and multi-agency participation to facilitate incorporation of related programs in the region. More specifically, the project was designed to 1) address the needs identified in the local program assessment; 2) enhance perinatal family violence screening and intervention; 3) improve the referral network between the local health departments and area family violence programs; 4) improve case management of prenatal clients experiencing physical and emotional violence; 5) enhance perinatal outreach and client recruitment efforts; 6) improve multidisciplinary health education and training around family violence and women's support issues; and 7) enhance community commitment to eradicating family violence (See Section II: Goals and Objectives for more specific project objectives).

D. Program Priority under which program is funded:

The NEBLP Family Violence program was funded under the healthy start perinatal health disparities program. The program is housed within the Perinatal Health and Family Support Unit and has the capacity to impact statewide efforts lead within this area.

E. Relationship to Title V MCH program and regional/national significance

The Family Violence project, like the NEBLP Program, is administered by NC DHHS- Division of Public Health, Women's and Children's Health Section (WCHS). WCHS is the state's Title V agency, and has extensive experience in administering a complex array of statewide programs which promote the well-being of women, infants and children. Maternal health, women's preventive health (including the statewide Title X program),

child health (including the state Child Health Insurance Program), services for children with special health care needs (including early intervention), nutrition services (including the state WIC program), and immunizations are just a few of the specific efforts implemented to address the needs of women, child, and families. Many of these programs are already designed to address specific needs of low to modest income families, along with statewide maternal and child health disparity issues. The Section's range of responsibilities and capacity for program management is reflected in the variety of programs/services developed, implemented, and administered. WCHS's broad scope promotes collaborative efforts while discouraging categorical approaches to the complex challenge of promoting maternal and child health. A key component of this approach was the cooperative effort between WCHS and the Division of Medical Assistance (DMA, the state Medicaid agency) that resulted in the development of the highly successful Baby Love program. The Baby Love program expanded Medicaid eligibility levels, increased reimbursement to providers, both public and private, and greatly expanded the range of services available to Medicaid recipients. WCHS's NC Baby Love Plus Program added wrap-around services to Baby Love's core service menu, enhancing and increasing the Section's resources and capacity to better serve women and children, particularly those living in counties with high infant mortality rates. This type of service expansion reflects the Section's commitment to providing families with resources that are easily accessible, comprehensive, and culturally appropriate. The infant morbidity and mortality reduction efforts of the Section are located in the Women's Health Branch (WHB). Recognizing the multi-factorial nature of infant mortality, WHB carries out a complex set of infant mortality reduction efforts e. g.

federally funded Healthy Start grants (3); Healthy Beginnings, a statewide minority infant mortality initiative; NC Sickle Cell Syndrome Program; high risk maternity clinics; support to 100 providers for provision of wrap-around care; funding to all five of the health departments in the project area through its Healthy Mothers/Healthy Children Block Grant). These efforts also included a focus on family violence prevention.

Violence against women is a public health priority in North Carolina as set forth in a health objective for the state for 2010. *Healthy Carolinians 2010: North Carolina's Plan for Health and Safety* contains the following set of objectives to improve the state of violence against women in the current decade: 1) reduce sexual assault; 2) reduce the rate of physical abuse by current or former intimate partners; 3) increase the number of sexual assault victims seeking and receiving services; and 4) increase the number of victims of intimate partner violence seeking and receiving services. Prior to the implementation of the Family Violence project in this rural northeast corridor of the state, most efforts had been introduced only in more urban and more densely populated areas. The integration of this intervention into NEBLP program activities provided WHB with an opportunity to discover the impact of a coordinated effort to address family violence in a five-county rural community. The outcomes and results provided strategies and information by which the Section, as a Title V agency, can better serve all families in the state. The lessons learned in North Carolina have the potential to impact the entire region and lessons learned can be shared regionally and nationally.

II. PROJECT GOALS AND OBJECTIVES

The goals of the project were to identify women at risk for family violence, increase community awareness and knowledge through training about family violence, and

coordinate a community response with a multidisciplinary team. Four program models address: the project area consortium, outreach and client recruitment, health education and training, and case management. The community perinatal health system objectives on the program level were: 1) To enhance perinatal family violence screening and intervention, 2) To improve the referral network between the local health departments and area family violence programs, 3) To improve case management of prenatal clients experiencing physical or emotional violence, 4) To enhance perinatal outreach and client recruitment efforts, 5) To improve multidisciplinary health education and training around family violence and women's support issues, and, 6) To enhance community commitment to eradicating family violence. The project partnered with the existing NC NEBLP Program, one of NC's Healthy Start Initiatives and addressed gaps in the system of care and needs identified within the project area. The Regional Consortium was in place under this funding. The consortium was developed as a means to bring together representatives from each of the five counties public health initiatives, community leaders and regional consumers to make decisions on future programs in the area. This grant application was developed with the full Regional Consortium approval. Since the consortium provides direction and oversight to the NEBLP Program, basic awareness of what defines family violence and the lack of sufficient resources in family violence programs throughout the region were important and had to be addressed through the consortium. Two objectives were addressed under this model:

- To increase membership of the consortium to include key family violence programs in the project region. Of note, there was no formal representation from the local family violence programs on the Regional Consortium prior to the program.

- To increase consumer and community Consortium members' knowledge and skills regarding the need for and availability of family violence services.

Outreach and client recruitment efforts within NEBLP were conducted by Maternity Care Coordinators (MCC), Community Health Advocates(CHA) and Maternal Outreach Workers (MOW). Although these staff worked closely with the perinatal clients and would at times be told about family violence that was occurring in the home, they had limited training or agency policy on how to address clients experiencing violence.

Creating an internal public health family violence program that could work in tandem with the existing MCC, CHA and MOW services provided another avenue for the staff to bring clients into clinic. In addition, this focus on family violence increased awareness in the community and among clients about the seriousness of the issue and potential health risks associated with the stress, physical injury and emotional instability caused by violence in the home. One of the main strategies behind this model was to create a level of continuity in service, to target referrals to the most appropriate agency, and to develop sustainable systems of care in the region. At a minimum, after the project ended, the MCCs would have a wealth of new knowledge and experience in family violence services and be able to address their clients who screen positive in a more effective way. Health education and training is one of the largest system level gaps in the project area. Both of these areas topped the list of needs for family violence prevention. Along with the efforts of the consortium to provide training on family violence to its members, education designed to increase awareness from individual to community-based organization levels was proposed for the project. During the first grant year, extensive training and education about screening for violence during pregnancy was completed.

The project connected with local university experts on violence to provide these trainings

and to begin workshops in the region to non-public health agencies such as social services and faith-based communities. When the project hired a domestic violence specialist in the region, several trainings were scheduled for each county's child health and infant mortality review boards. Multidisciplinary groups including police, school administrators, and social services personnel were provided with information about the family violence program and approached to create a region wide task force. A policy statement and protocol specific to domestic violence was written and implemented for each health department. The domestic violence specialist also provided training to each staff member on the policy which incorporated the most up to date information on laws pertaining to domestic violence in the state of North Carolina. The main objective was:

- To provide staff continuing education updates/trainings on the general dynamics of family violence, use of the screening tool, and protocol for referral. Prior to the program implementation, family violence was not a priority focus.

Our fourth model addressed case management. Although there were MCC and MOW services in place for the women in maternity clinic, there were no clinical social workers or trained counselors on staff at any of the five project health departments. A position to support the staff with case management, crisis intervention and counseling for those patients identified as experiencing family violence was needed. The strategy was to increase direct services to these clients, rather than simply making a referral to an outside agency to which the client might be less likely to go to on their own. Providing this service also meant having an individual onsite specifically trained in violence and its effect on health and healthcare as well as an advocate to supplement the traditional referral to mental health. No other region of health departments in NC had such a staff position. Again, the model was incorporated into the original grant application to promote

sustainability of the family violence services. The domestic violence specialist worked closely with the perinatal clients' MCC case managers. The MCC administered the initial screening and in some cases, dependent upon the availability of the domestic violence specialist, did initial crisis counseling. Therefore, at the end of the grant period, family violence was an integrated focus in maternity clinic. There were four objectives identified under this model:

- To increase the number of clients enrolled in case management services who report being satisfied or very satisfied with services.
- To screen all perinatal clients for family violence. Of note, screening tools specific to family violence did not exist before the project.
- To appropriately refer all high-risk women and their infants, who were seen by Maternity Care Coordinators (MCCs), to the Regional Family Violence Clinical Social Worker or crisis intervention center.
- To increase the number of high-risk women and their infants who receive needed family violence support services.

Successful achievement of the preceding goals/objectives assisted NEBLP program staff, Regional Consortium members, and local partners in concretely addressing the problem of family violence in the five-county region by strengthening a functional and effective family violence system of care.

III. METHODOLOGY - Strategies Used to Accomplish Project Goals/Objectives

In this rural, economically depressed region, there were several crisis intervention resources available to women; however, there was no system of care for women that addressed their problems in a holistic way. In preliminary discussions with local providers (local health departments and crisis shelters), the following critical areas were identified. They fell into four major areas: training, service expansion, infrastructure development, and community outreach. In order to increase awareness and gain support

in the area for an initiative aimed at combating these gaps, efforts to strengthen the system of care became the main focus of the grant. The grant activities in parallel with the models listed in the goals and objectives section covered five major areas across the three levels of community, systems of care, and services: (1) regional consortium involvement, (2) training, (3) linkages and coordination across service systems, (4) screening and case management and (5) referral protocols.

Community Level: Regional Consortium

The NEBLP Regional Consortium provides direction and oversight for the Baby Love Plus Program and the Regional Consortium was also tasked with carrying forth the work of the Family Violence program. The FV grant application was developed with full Regional Consortium approval. At the December, 2001 Consortium meeting a vote to allow the Project Director to develop this grant application under the guidance of the chair and co-chair was cast. The Consortium was an integral component of the Northeastern Baby Love Plus Program as can be discerned by their encompassing relationship to the Women's and Children's Health Section and overall Northeastern Baby Love Plus administration (**see Attachment A-2**). The Consortium includes three standing committees and the local county action committees: (1) Public Education/Awareness, (2) Program/Service Delivery, (3) Data Analysis/Review (**see Appendix B-3 for committee descriptions**). According to by-laws, each of the committees has at least one consumer representative. Membership on the Regional Consortium was expanded to include a liaison from each of the local family violence programs. The Regional Consortium meetings also afforded consumers and community members the opportunity to network with staff from the local health departments and

other health and human service providers. This networking was an important means to bridge the gap between providers and the community, giving each the opportunity to express concerns about service delivery and community involvement.

Linking with community- based organizations in northeastern North Carolina was essential to assure availability of services for clients. Therefore the regional consortium released a request for applications (RFA) for regional community based organizations to offer activities designed to address family violence. After applications were reviewed by members of the regional consortium (BLP staff, community members, consumers and health care providers), two fatherhood programs were named as community partners: UHURU and North Carolina Fatherhood Connections Network.

Community Level: Training

Training took place at two levels: agency/provider (care coordinators, other service providers), and community (general, support groups, male focused). Ongoing training on women's health, family violence and psychosocial issues for care coordinators and other health and human service personnel emphasized integration of service delivery systems to facilitate removal of barriers to service. Four one-day workshops were held with the local health departments regionally during the first year and then two one-day workshops (Family Violence Community Forum & Family Violence Summit) in years two and four. Approximately 465 care coordinators, health care providers and administrators participated in these trainings.

Four types of training were provided to the general community concerning family violence issues. A Family Leadership Development Retreat to reach high-risk families was held each year of funding. The two community partner fatherhood organizations

provided family violence training to males. A session at the Annual Healthy Start Training Institute, the largest consumer educational conference in NC, was devoted to family violence. The Northeastern Regional Consortium devoted two meetings per year to family violence.

Churches and clergy (pastors, ministers, etc.) are extremely important in the lives of minority populations in rural areas. Churches are not only the center of religious education, but are frequently the center of community activity. Clergy are highly respected, and provide guidance in both spiritual and family matters. Project members felt it was essential to obtain feedback from members of the clergy to enlist their collaboration. Three focus groups were conducted with pastors to gauge their training needs in the area of domestic violence. Based on the responses from the focus group, a training specially designed for clergy members was conducted. These sessions focused on helping clergy understand the issues that impact family violence, and how they might address family violence.

It is very important for communities to develop services responsive to the needs of men as well as women involved in family violence whether as batterers or victims of abuse. Thus in addition to the pastoral focus groups, two additional focus groups were held to capture the domestic violence perceptions of African American men. The responses were used in the development of culturally relevant intervention strategies.

Systems of Care Level

Grant funding was utilized to provide facilitating services for families to reduce barriers to service for women experiencing abuse. A Regional Family Violence Clinical Social Worker (SW) was hired to provide clinical counseling, case management and referral to

social, financial, and vocational assistance programs. In conjunction with the area family violence programs, group counseling/support groups were established and expanded.

(See appendices for chart depicting the project's Family Violence Continuum of Care.)

Services Level: Screening and Case Management

Considerable effort was expended in year one of the project developing a set of screening and assessment tools and training personnel in local public health clinics across the region in their use. The intention was to screen clients prior to delivery and periodically in the postpartum period. Because the project had difficulty finding a domestic violence/social worker specialist, the actual screening and tracking of clients began after the second year, limiting longitudinal information to a six-week postpartum span.

The Maternity Care Coordinators (MCC) screened women in the prenatal clinics at the local health departments (Halifax, Nash, and Northampton counties) and at private provider OB/GYN practices (Gates and Hertford counties). All prenatal clients for these clinics were screened for FV using the newly developed tool. Each woman was screened upon entry into prenatal care and at least once per trimester throughout pregnancy and then again once at the six-week postpartum visit. For a complete description of the process and content of the screening, assessment, and follow-up services, see report in

Appendix.

Systems of Care Level (among agencies): Tracking Women Over Time

During the initial program planning phase of the grant period, one of the most prominent gaps in service identified by key participants in the project area was a comprehensive system of care for handling domestic violence cases. Many of the health departments did not screen for family violence prior to the grant period and therefore had few dealings

with the agencies and task forces in the area devoted to family violence. During the grant period and especially once the Regional FV Clinical Social Worker was hired, the system of care pertaining to family violence victims served by the health departments grew exponentially. Meetings were held bringing together key community partners such as DSS, the school system, faith-based communities, and sheriffs departments to discuss how public health could better collaborate with each key partner. She also spoke at local county child protection team meetings and trained members on the connections between family violence and infant mortality rates. The health departments now have a representative on the regional domestic violence task force which allows them closer communication and access to the sheriffs departments, District Attorney's offices, and DV shelter executive directors.

V. EVALUATION METHODS FOR ASSESSING PROJECT EFFECTIVENESS

The focus of the evaluation was on perinatal systems of care, the services provided to program participants and their families, and the health status of those receiving Healthy Start funded services. By adding several new system-level assessment tools and expanding our range of community surveys, the BLP evaluation team provided supplementary information to determine the effectiveness of the enhanced case management and training activities. The evaluation was also designed to assess feedback from providers and consumers, and sustainability of program efforts.

Evaluation Activities

The evaluation of the BLP program assessed each of the three program components, Case Management, Outreach, and Health Education and Training, with an additional focus on systems of care for addressing family violence - both identification and management of

those women at highest-risk and in need of additional support and services. The evaluation also assessed the Regional Consortium, the model that guided the Initiative with the mission of addressing racial disparities in utilization and effectiveness of services to address family violence. Specifically, the evaluation aimed to answer three questions focusing on community involvement, systems of care, and ultimately, services provided. Did the program improve: (1) the community's voice and sense of satisfaction with efforts to improve women's health and well-being through screening and enhanced case management for family violence during the perinatal period? (2) the systems of care specifically for program participants identified as high-risk for family violence in the target area? and (3) the services for management of factors resulting from family violence among BLP program participants in the study counties? The evaluation focused on three key areas related to care in the perinatal period for women experiencing family violence:

(1) Improved Systems of Care for High-Risk Women in the Perinatal Period

- Are there now appropriate screening tools in place and being used on a regular basis?
- Is there an effective referral protocol in place?
- Is there a system among agencies to track women referred with a history of FV?
- Have public health and social service providers received trainings that increased their awareness and skills in the area of family violence in the perinatal period?
- Did the Regional Consortium establish a special focus to facilitate networking and skill-building opportunities related to family violence in the perinatal period?

(2) Identification of Women in the Perinatal Period Who Are At-risk for Family Violence

- Do women know that services are available and where to go to be screened?
- Did screening criteria accurately identify those women at highest risk?
- Are the highest-risk women subsequently offered the additional care needed?

(3) Treatment of Women At-Risk for Family Violence in Perinatal Period

- Were those women identified as high-risk appropriately tracked?
- Were women assessed as needing services appropriately referred for care?
- Did the women referred for care to other agencies receive the services needed?

The overall objective in evaluating the expanded emphasis on family violence within the BLP program was to ensure that the program was providing risk assessment, referral, monitoring, facilitation, and follow-up on services for the highest risk participants identified as needing more intensive case management services. The evaluation:

- documented system-level information on staffing capacity;
- verified the existence of written protocols for conducting risk assessments;
- ensured the incorporation of sensitivity training for local staff and providers; and
- collected and summarized participant-level information on services provided.

In terms of case management, although the first focus was to document the functioning of the case management model in terms of numbers of women reached, timing of entry into services, and effective tracking and referral, a second and equally important focus was on the systems of care, provider networks, and community/agency partners that serve and support these systems related to those participants identified as being at especially high-risk during the interconceptional period.

Data for evaluating program objectives were obtained from the following sources.

A set of clinical screening and assessment forms were developed for use with family violence contact and referral information. The forms included information on screenings and referrals made by MCCs or the LCSW on all postpartum BLP participants. The data forms were developed by the evaluation staff and processed on a monthly basis into Excel® spreadsheets. The evaluation team worked closely with the BLP staff and local

maternity health providers in the region in the development of clinical screening tools and tracking forms to ensure complete documentation of services provided and clients served with NEBLP Family Violence Program funds.

A series of seven community-based focus groups were held throughout the region.

Emphasis was given to eliciting feedback from males in the project area, and also from leadership within the local faith community. Feedback on domestic violence perceptions among rural African American men and rural African American ministers was obtained.

Participants were advised, “It is very important for communities to develop services that are responsive to the needs of men who batter or who find themselves victims of battering by an intimate partner.” Discussions centered on questions about definitions of FV, familiarity with FV (personally), how to intervene at family and community levels, and knowledge of local services.

Three focus groups with rural African American ministers were held. Participants were advised, “Churches are vital informal resources in communities, especially in rural settings. Ministers are highly respected and individuals often seek their guidance and advice. Your thoughts and opinions about domestic violence will assist the project with helping ministers and churches enhance their resources for domestic violence intervention and prevention.” Discussions centered on questions about prevalence of FV, familiarity with FV (among their congregants), knowledge and awareness of signs of FV, contributing factors, pastoral training on topic of FV and how to manage counseling, awareness of local services, opinions about effectiveness of interventions for victims as well as perpetrators, and personal experiences with advice given to congregants regarding family violence.

And finally, focus groups were held with women in the region to elicit their feedback about general perceptions of health care services and various issues related to taking care of themselves and their health needs. A total of 22 African American women, aged 19-52 years in two rural counties, participated in one of two focus groups. Most of the women were unemployed single mothers receiving Medical Assistance.

A Systems Survey was conducted through a mailed questionnaire to key informants in the project area. The roster of participants was finalized in collaboration with the Community Consortium members and BLP staff to ensure that all appropriate agencies or community representatives that related in some way to family violence were included. Surveys were mailed to 58 people. Respondents worked in medicine, law enforcement, fatherhood initiatives, maternity care coordination, local domestic violence shelters, faith communities, and as community health advocates. About 35% were members of the local consortium and approximately 69% attended family violence training during the grant years. The Survey covered questions across the different levels of program activities included in the project: knowledge of and attitude towards FV related issues, awareness of specialized services through local agencies; agency level issues such as staff comfort in dealing with clients experiencing family violence, satisfaction with the project; and community/system level issues: overall changes stemming from the project, overall project success and sustainability of FV efforts for the Region after the grant ended. Subsequent to the mailed survey, the program elicited feedback by telephone interviews from program area experts on how well the BLP program was operating from their standpoint.

Sixteen key participants who contributed in various ways to the grant project were selected for an in-depth interview. Two members of the evaluation team, one as the **interviewer and one as the note taker participated on each call. An interview guide (Appendix)** was developed by the evaluation team with questions regarding the achievement of project goals, patient management, case management and screening, the post-grant system of care, building a state-wide model, and dissemination. A customized interview guide was developed for each person. There was excellent feedback: 100% participation in the telephone interviews and an 84% completion rate for the mailed surveys. Findings are included in the future sections.

V. Project Accomplishments: Results, Outcomes, and Lessons Learned

The Results and Outcome section will focus on the activities that took place during the grant period across the three levels of program effort (Community, Systems of Care, and Services) in the areas of 1) Consortium, 2) Health Education and Training, 3) Outreach and Client Recruitment, and 4) Case Management and Referral. Data were collected through a community-based survey, focus groups and clinical screenings. This section will also describe the screening and assessment processes used. The Outcome Section will address the questions posed by the evaluation in the grant application and describe the impact of the grant activities on the region. Lessons learned will be shared across the different levels and areas of program effort.

Program Results at the Community Level: Consortium

The Northeastern BLP Regional Consortium serves as a significant decision-making body for Baby Love Plus. The Consortium consists of members of key community-based organizations, the health departments, community residents and consumers who discuss

and carry out activities that impact the system of care in the region. The Consortium is led by the Northeastern Regional Manager who coordinates efforts to raise awareness about the family violence grant and encouraged communication among the key partners. In addition to the Health Departments, key partners included the Division of Social Services, police, women's health organizations, and fatherhood programs. The first objective was to assure that the membership of the Regional Consortium reflected representation from the key family violence programs in the project region. There was no formal representation from the local family violence programs on the Regional Consortium prior to May 2002. The three family violence shelters (Hannah's Place, My Sister's House, and Roanoke Chowan SAFE) remain active participants in both the Regional Consortium and in overall program development. Of the 18 meetings during the grant period 14 were attended by a staff member of at least one of the shelters. Partnership with the three family violence shelters was very beneficial to the project and the shelters. The shelters faced major challenges during the project period as the state passed legislation that would cut funding given to the family violence shelters. The struggle to offer services was a constant battle due to limited resources. One of the shelters was at the brink of closing down prior to our collaboration. All three facilities felt that additional resources would allow them to expand their outreach services and in-house support groups. However, two major barriers to achieving these goals were marketing in rural areas and transportation. All three sites utilize billboards, a major method of advertising in rural northeastern NC, in strategic locations as a means of marketing. After the erection of billboards, the number of calls to the shelters significantly increased. One shelter reported a forty percent increase in the number of

calls. The other major obstacle was transportation. With the additional funding, the agencies were able to provide off-site support groups at various locations throughout the region. These private meetings allow victims of abuse the access to services without having to travel to an agency. During the meetings clients were given presentations from law enforcement officials who shared information regarding the legal system, how to protect yourself from abuse and to provide a safe home environment for children. Cellular phones with direct calling to 911 were given, cost free, to clients who did not have access to a phone or who often found themselves denied use of the phone in the case of a domestic event.

One of the key areas that all three shelters identified as an area they wanted to strengthen was the relationship with the local health departments. The family violence project found that local health departments were not fully aware of the services offered by the family violence shelters, nor did they perceive them as a referral agency. Led by project personnel, meetings between representatives of health departments and shelters were arranged, and as a result memoranda of understanding, procedures and protocols were developed. Clients who screened positive for family violence were referred to the local family violence shelters. Another positive outcome was the ability for the shelters to hire additional staff. With the introduction of new marketing ideas and MOU with the health departments, new clients sought services. Thus the number of call to the 24-hour crisis hotline dramatically increased. Two of the three shelters hired a person to manage the phone calls. Prior to this, the calls were answered via answering machines. It was noted that calling an answering machine during or after a domestic event, particularly on a weekend was inadequate. The shelters also wanted to be able to have staff in the

courthouse during domestic violence court sessions. Since cases for domestic violence and sexual assault were held on different days, staff had to be available on multiple days. Even with the additional funding, it was a challenge to have staff in the courthouse whenever needed.

Consortium members' knowledge of and skills in providing family violence services increased. During the first grant year, a consumer survey was distributed throughout the region and to members of the consortium. This survey provided the project with baseline data on awareness levels and an assessment of the system level gaps as perceived by those individuals receiving services in the project area. The Regional Consortium Survey (Conducted June/July 2001) revealed that 73% of respondents felt knowledgeable about risk factors related to poor birth outcomes and 27% felt neutral or less skilled in applying that knowledge to help families. There was very little awareness about family violence as a possible risk factor for infant mortality. This changed as a result of program efforts. Educational components focusing on family violence issues as they related to different populations became a regular practice during consortium meetings. Topics included elder abuse, anger and stress management, and the effects of family violence on children. The Healthy Start Training Institute of 2003, included a session on "Children's Response to Domestic Violence" where 95.4% of participants saw the session as being relevant to their community and work and 86% rated an increase in knowledge and skills as a result of the training. 85 people attended the Consortium's Family Leadership Development Conference where they had the opportunity to do skill building activities. This conference proved effective in nurturing consumer advocacy skills and personal growth. The focus groups (described in Evaluation Methods and discussed in fuller detail in

Outcomes below) for African American males' perceptions of domestic violence included a total of 21 participants. Both groups felt that domestic violence occurs daily and that it is kept "undercover" because it is considered embarrassing. There was a discrepancy between the groups about the prevalence among Blacks and Whites. One group felt that it happens more in the White community "because they broadcast it". Another group felt that "There is just as much violence in white homes as in black homes". The Northampton second group was more analytical in its response. They emphasized that "Blacks are exploited, and there aren't any alternatives in their community; the needs of Black men are not being met by the community because of stereotypes." The majority of the participants acknowledged knowing others that were in abusive relationships, which included women who were abusive to men. Both groups felt that domestic violence derived from drug and alcohol use, stress and lack of financial resources. A question asked in both focus groups was, "How should an African American man intervene with African American men who are abusive?" The men in both groups emphasized caution when intervening. They felt that batterers would respond better to someone that they know and trust. Approach the abuser with a nonjudgmental attitude and let them know you care about them. Both groups acknowledge that the batterer should be told that, "you are wrong". They also stated that it was important to emphasize to the abuser the legal consequences that could derive from his negative practices and how he would be held accountable by the legal system.

The series of focus groups with African American ministers in the project area focused on establishing contacts in the faith community and capturing the thoughts and perceptions of ministers on domestic violence in their congregation and community. The

ministers made recommendations regarding information that would be helpful to include when designing a training session. In addition, many of the ministers stated they had no idea about any available resources to refer people seeking help.

The feedback from the ministers was used to develop three-hour training sessions that were conducted in 2004-2005. The training included information on the religious aspects of the problem, myths, definition, abuse patterns of control, cycle of violence, characteristics of abuse and victims and faith-based interventions. In each county, the local domestic violence program assisted by presenting information about available resources and mechanisms for making referrals.

The effort to provide the faith community with information and skills to respond to domestic violence was an essential component to building an informal system of care in these rural communities. Future endeavors will include training efforts with ministers' wives, church auxiliaries and youth groups. It was noted that it is important to establish alliances with ministers who are in key leadership positions within the different denominations and to identify nondenominational coalitions in the community. Feedback from these focus groups will be utilized to guide future plans for family violence prevention as designed and agreed upon by the Consortium.

In addition to establishing collaborative efforts with family violence shelters and organizations of the faith community, the project sought the partnership of community non-profit organizations. The program subcontracted with UHURU and North Carolina Fatherhood Connections Network (NCFCN). The two agencies served in the capacity as fatherhood programs. Both offered services addressing substance abuse, parenting and family violence and had established a referral system with the judicial system. Men who

were found guilty of domestic violence were given the option of going to jail or enrolling with the agency and completing their four-week curriculum “Fragile Families”. This curriculum addresses family violence, parenting skills, stress and anger management, job readiness and developing health relationships. Both of the community subcontracts were instrumental in the program’s ability to reach its goals. However, again due to the lack of overall resources in the rural region, NCFCN had to cease all activities due to lack of funding support. Prior to the closing of NCFCN, UHURU and NCFCN united to sponsor Community Fatherhood Summits that were well attended by residents. UHURU has remained as the sole community support system for fathers in the northeast. UHURU has also increased community awareness of a number of cases where men have been abused by their partners. In cases where men are suffering abuse or being attacked by a partner, clients have sought help from UHURU. UHURU has provided a unique service in providing male clients who have been abused 24 hour shelter at a local hotel. (The financial resources to offer this service come in part from the family violence project). This is a “cooling off period” that gives the man a chance to think clearly and regain his composure rather than returning to a hostile home and retaliating.

Program Results for Outreach and Client Recruitment

The Outreach and Client Recruitment objective was to increase the proportion of the eligible women enrolled in care coordination services. Prior to the grant period about 35% of the women eligible for service were enrolled for MCC services. Aggressive outreach tailored to the individual communities is done in each county by the Child Health Advocates (CHA). There are eight Community Health Advocates (CHA) assigned to the NEBLP Program. The CHA specialized role is to provide community

outreach in an effort to recruit and retain women into prenatal care. The CHA participate in quarterly staff meetings that incorporate an educational session coordinated by the regional manager. During the implementation of the Family Violence project, the CHA received training in the area of Child Abuse that focused on the key areas of physical and sexual abuse. It was noted that while conducting outreach the CHA often come into contact with many children in the community. In some cases, the CHAs suspected abuse but were not sure what their legal responsibility was in suspected cases nor how to handle any interactions with the suspected perpetrator. In Spring 2003, a training was designed by the Regional Manager and conducted by the supervisor of Child Protection Services of the Nash County Department of Social Services for CHAs. Hence, when a CHA went into a home where family violence was suspected, they knew the kinds of questions to ask and could offer services through the health department that did not carry the stigma often attached to referral to a DV shelter or the police.

The project gave the MCCs and CHAs in the region more opportunity to recruit a wider range of women into maternity health services. Although the MCCs conducted the primary screening of the maternity patients, those screenings took place after client recruitment. Each CHA was a part of the initial family violence trainings done in each health department on the new screening tools and clinical services that would be provided for each health department by the FV Clinical Social Worker. Through the family violence program, more succinct and specialized services were provided for each client and increased the number of women receiving and remaining in health department services.

Post-grant activities include key informant interviews with sixteen professionals in the region who had significant impact on the project. Each interviewee was asked about the project's impact on client outreach and recruitment. As will be discussed more under Outcomes, feedback indicates a very positive response in the community to efforts that raised awareness about the family violence project and the additional services each health department could provide. One cannot say definitively that these activities were the direct cause of an increase in client recruitment; however, most key participants such as MCC and health directors felt clients were confident they could come to the health department for services regarding family violence. Patient data collected by the FV Clinical Social Worker and analyzed as part of the evaluation activities outlined client satisfaction with the health care services and referrals received through their health care providers.

Program Results for Health Education and Training

Training was one of the most important aspects of the grant to strengthen the system of care in the project area. Originally, the main objective was to provide six staff continuing education updates/trainings on family violence issues: the general dynamics of family violence, use of the screening tool, and protocol for referral. This objective was greatly exceeded. Family violence had not been a focus in health department staff meetings or in most of the community based health organizations and agencies. During the project period, trainings were held in each health department on screening, policy and protocol and service implementation. Many additional trainings were held in the community where members from various agencies, child protective teams, school systems and police departments were brought together to discuss this family violence project and share their own strategies for dealing with family violence. One of the training highlights for the

project was the **Family Violence Community Forum held in October 2004** (see agenda in appendix). One of the key concerns in the region was the lack of awareness among the agencies that provided key services to clients related to family violence. It was noted that many agencies did not know of other agencies they could collaborate with as a means to maximize their available resources. Administrators were often not aware that North Carolina had recently implemented new guidelines and revised best practice models. Thus, the Family Violence Community Forum was a highly anticipated event. One hundred people attended from the NC State Attorney General's Office, law enforcement and magistrate offices, domestic violence shelters, community-based organizations and healthcare facilities. A Regional Domestic Violence Summit in May 2006 was a follow-up training to the Family Violence Community Forum with 225 in attendance and focused on "Safety and Treatment for Effective Prevention Systems". **(See agenda in appendix)** Currently (2006), the Domestic Violence task force remains in place with regional participation and monthly meetings. All regional agencies concur that it would be valuable to have an annual regional conference, to stay abreast of new laws, guidelines, practices and methods. The Regional Manager and Regional FV Clinical Social Worker also made a presentation to each county's Child Fatality Task Force and to the Area L AHEC (Area Health Education Center) Minority Healthcare Professionals. The Regional Clinical SW worked with the five local health departments to improve their triage system for referring patients who screen positive for family violence. She assisted each department in developing and refining their screening policies and protocols. A major focus of our initiative was also on system development. Project staff worked with the local shelters to better connect them to the local health departments. Memoranda of

Understanding were developed between the local health departments and the family violence shelters.

Program Results for Case Management

The primary objectives for case management was to screen 100% of the MCC eligible population for family violence, to appropriately refer 100% of those patients that screened positive to the FV Clinical Social Worker, and to provide services client would report they were very satisfied with these services. Throughout the grant period, sustainability of the project's efforts was an overall objective. The fourth objective under case management was that 100% of high risk patients would be referred for Family Care Coordination services post-grant. In 2005, the NEBLP program added family care coordination into Baby Love Plus services. Each health department hired a Family Care Coordinator (trained social workers with public health and maternity experience) who now follows each mother identified as high risk by the MCC. High risk included the patient who screens positive for substance abuse, postpartum depression, or mental health issues and now also includes family violence. Although this intervention is not a substitute for direct clinical and on-going services for domestic violence during the time of pregnancy and through 2 years postpartum, as the regional counselor's position provided, the FCC does provide a supportive role that we hope will lessen the number of fetuses and children exposed to high risk behaviors including family violence. In addition, there are now policies and procedures in place which require actions to be taken when a patient screens positive for violence. The policy covers how to discuss safety planning, what to do if a child is a witness or victim of abuse, documentation, referral protocol, workplace violence and collaboration with community based organizations.

All maternity patients in each of the five counties were screened for family violence, once during each trimester and again at 6 weeks post-partum. From November 2003 through April 2005, 1252 women were screened. Of those, 1110 were MCC eligible. This represents 100% of those enrolled prenatal clients. Of those screened, 64 were positive and were seen for further case management by the Regional Clinical SW.

The project's largest impediment was the greater than anticipated time it took to hire the Regional Clinical Social Worker. Finding enough qualified individuals to fill professional positions with increasing educational requirements has been an up-hill battle for rural areas such as northeast North Carolina. This issue also highlights reasons for our shortage of police officers and understaffed domestic violence shelters. After an extensive, multi-state search, the clinical social worker was hired in September 2003. Since this crucial position was not filled until more than one year into the grant period, only 1 year and 6 months of patient data could be collected.

Patient education on family violence was also a large part of the case management and awareness efforts. Each maternity patient was provided with incentives supported by the family violence grant initiative. Incentives included pamphlets on healthy pregnancy, the first year of a baby's life and the effects of domestic violence on health and children. Posters and educational materials were placed at each health department as well as information about the family violence program and the health department's role in family violence prevention.

According to the 2002 Consumer Survey the majority of patients were already somewhat or very satisfied with their MCC services prior to the grant. The family violence services served to enhance the MCC role and successfully filled a service gap according to

respondents to the key participant interviews and system survey.

Program Outcomes and Accomplishments

In this section we describe what the grant accomplished and the outcomes or findings for the program goals related to addressing family violence in the perinatal period. Through focusing efforts across program models already in place and active through BLP (Community Consortium, Education and Training, Outreach, and Case Management and Referral), results varied by system of care—at the community level, at the provider-agency level, as well as at the family/individual level of service.

Outcomes Related to Community Awareness of the FV Problem:

1. The Regional Consortium established a special focus to facilitate networking and skill-building opportunities related to FV in the perinatal period.

- The consortium was successfully used as a means to bring together representatives from each of the five counties public health initiatives, community leaders and regional consumers to make decisions on future programs in the area.
- Membership in the consortium increased with the addition of representatives of key family violence programs in the project region. There had been no formal representation from the local family violence programs prior to the program. As of May 2006, the three family violence shelters remained active participants in both the Regional Consortium and in overall program work. In addition, the Region's Family Violence Task Force placed the Executive Director of the Roanoke Chowan SAFE on its board of directors. The Family Violence Task Force is comprised of judges, sheriff's department staff, public health department staff, District Attorney's office, and other key community partners.

2. Community awareness about family violence increased.

- "A focus on family violence increased awareness in the community and among clients about the seriousness of the issue and potential health risks associated with the stress,

physical injury and emotional instability caused by violence in the home.” (Quote from Key Informant Survey, health care worker in local HD)

- The majority (98%) of respondents to the Systems Survey reported that there was more community awareness of FV at the end of the project (2005) than in 2002.
3. *Consumer, Consortium Member, and Provider knowledge and skill levels increased regarding the need for and availability of family violence services.*
- BLP Staff and Agency Representative training sessions (Dec 2002-Jan 2003) resulted in 138 providers trained with an increase in knowledge about FV (75.4% strongly agree; and 23.9% agree); and an increase in skill level (64.5% and 31.2% respectively).
 - The Regional Consortium Survey (Conducted June-July 2001 pre-project) revealed that 73% of respondents felt knowledgeable about risk factors related to poor birth outcomes and 27% felt unsure or less skilled in applying that knowledge to help families.
 - The Regional Consortium meeting in February 2004 was devoted to training on Elder Abuse. There were 31 Regional Consortium members present. Consumer and community members represented 33% of the attendance. 78% of the members completing the training and assessment form (19) noted an increase in knowledge and 74% reported an increase in skills as a result of the training.
 - The Regional Consortium meeting in August 2003 trained on the Effects of Family Violence on Children. There were 36 Regional Consortium members present at the meeting of which 31 completed the training and assessment form. Consumer and community members represented 67% of the attendance. 84% of the members who completed the training and assessment form noted an increase in knowledge and 42% reported an increase in skills as a result of the training.
 - The sixth Annual Healthy Start Training Institute (July 2003) included a session on Children’s Response to Domestic Violence. 95.4% saw the session as being relevant to their community and work. 86% reported an increase in knowledge and skills as a result of the training.
4. *Community commitment to eradicating family violence has been strengthened*

- From a Regional DV Clinical Counselor: *"From my perspective, yes, the project met its goal of enhancing community commitment to addressing FV, I think, because we raised awareness locally and communitywide and brought the seriousness of the subject to light. (For) a subject that not many people have been trained on or talk about I'd say there was definitely an enhancement and the community's commitment to do something about it. Especially toward the end of the grant when the momentum was building and linking public health to other sectors. People were very disjointed before, and no one was communicating so I think we increased that commitment level by having this unique project going on in the area."*
- From a local health dept. manager: *"We came a long way, there was a lot of buy in. The task force is moving forward. I went to a training back in June (2004). There were three Judges there. I have no doubt the focus on FV will continue, because of Judge K. I know that the sheriff's department and the DV specialist were a big part of the team moving this forward. Very important was to have collaboration among agencies. 100% we met this goal"* (of enhancing community commitment to eradicating family violence).
- The Local Health Systems Action Plan adopted by the project area's Region included a major emphasis on addressing underlying issues of family violence: maternal stress, fatherhood and relationship skill building, and housing stability. The Region's Action Plan is implemented through the BLP Consortium's County Action Committee. The group met intensively during the grant period, conducted trend analyses of local and Regional data, and created a number of summary documents of interest locally (**see Appendices for full reports and details**).

Outcomes Related to Health Systems Improvement

1. A number of outcomes were realized as a result of Service Expansion:

- In-house counseling for patients now includes crisis counseling and support groups.
- Long term follow-up of victims became available during the grant and was shown to be useful.
- Substance abuse assessment became possible as part of FV screening.

- Services offered through Safe Shelters for each county were identified and strengthened.
 - Family violence shelter services expanded to provide linkages with local public health partners.
2. *A number of outcomes were realized through Infrastructure Development:*
- Development and implementation of a screening tool to identify victims of family violence (see below for full discussion of outcomes).
 - Improved system linkage between public and private service providers including local family violence programs.
 - Improved follow-up of women referred for psychosocial counseling, crisis intervention, or related specialized need services.
 - *“The project demonstrated how to build on the community and the strengths that are already there.”* (Quote from Systems Survey Respondent)
3. *Knowledge and skills for staff of local public health and community partner agencies serving clients with FV issues were increased through focused FV trainings.*
- Extensive and on-going training for health and human service providers around family violence dynamics, including: training for family violence program staff on women’s health issues; namely HIV and STDs; training of law enforcement personnel on family violence issues; and women’s empowerment training.
 - Training sessions (5) conducted during project year 2002-2003 ensured local staff had the necessary skills to screen for violence. Subsequent trainings focused on technical assistance and individual-agencies issues needed to improve their system for screening and referral.
 - By the end of the program period: more than 85% of trained staff reported a significant increase in knowledge and skills regarding MCH topics and community empowerment issues.
 - In-service seminars at monthly MCH staff meetings: family violence had not been a focus. After start of the project (from the 2002 staff trainings), 75.3% of staff reported an increase in knowledge around family violence issues; 65% reported an increase in

skills related to family violence screening and assessment. The project connected with local university experts on violence to provide these trainings and held workshops in the region for non-public health agencies such as social services and faith-based communities **(see appendices for copies of materials)**.

- Each county’s child health and infant mortality review boards received training and presentations on FV **(see Appendices for copies of materials)**.
4. *Awareness of new services available as a result of the FV grant increased among local perinatal providers and staff in local agencies who were community partners.*
- “The project made participants much more knowledgeable about the resources available.” (Quote from Systems Survey Respondent)
 - “The project gave participants more knowledge of the options for follow-up.”

System Survey Responses from local providers and agency partners (n = 59), Spring 2005	Aware of Service	Not Aware of Service
Prenatal screening for FV at our local health department/public health clinic	100.0%	0.0%
Assessment of health service needs	93.1%	6.9%
Follow up by FV Social Worker Specialist	96.4%	5.6%
Counseling and mental health services	89.7%	10.3%
Referrals to local shelters, safe houses	96.6%	5.6%
Other referrals (mental health, substance abuse)	93.0%	7.0%

- Multidisciplinary groups that included police, school administrators, and social services personnel attended presentations about the family violence program and a region-wide task force was created as a specific outcome of this assembly.
5. *Formal relationships were established between public health and other agencies in the community to partner on issues of FV and needs of clients with violence-related risks.*
- Memoranda of Understanding were developed between the local health departments and the family violence shelters.
 - Local staff members are more comfortable knowing what to do to help clients with FV issues and are better able to serve their clients who have history of FV either during or after their pregnancies.
6. *Standards of care for identifying, treating, and referring clients with FV needs were established, implemented, and supported as a result of the FV grant.*

- A policy and protocol specific to domestic violence was written and implemented for each health department **(see Appendices for copy of policy and procedures manual)**.
- The domestic violence specialist trained each staff member on the policy. Trainings incorporated the latest information on laws pertaining to domestic violence in the state of North Carolina **(see Appendices for copies of training materials)**.

Yes	No or Not Sure	<i>FEEDBACK ON LOCAL POLICIES and PROCEDURES FOR FV</i>
95.0%	5.0%	I am aware of the FV policies that exist in my agency.
89.5%	8.5%	I am aware of the document “Responding to Violence Against Women: A Guide for Local Health Departments” as a resource to me in my work.
89.5%	10.5%	I understand the different types of abuse and how to identify them in my clients.
84.2%	15.8%	I know how to assess risks and needs of clients who may be experiencing abuse.
89.5%	10.5%	I know the procedure for providing referrals and assistance to my clients who may be experiencing abuse.
84.2%	15.8%	I know the steps required and information necessary for documenting abuse.
84.2%	15.8%	I understand the procedures for following up and the questions that are essential to be asking any of my clients who have or are experiencing abuse.
79.0%	21%	I know what the procedures are and what my responsibilities are as a provider if a batterer is present when a patient screens positive for domestic violence in our clinic.
58.0%	42%	I have had occasion to implement some of the FV policies and procedures.
95.0%	5.0%	The policies and procedures make sense to me and I am comfortable with them.

Outcomes Related to Case Management and Modeling Service Provision:

The purpose of the case management component of the project was both to deliver needed services to pregnant MCC clients experiencing FV and to enhance the capacity of agencies and organizations in the Region to collaborate in offering needed FV services. The development and implementation of screening and assessment tools and subsequent referral to clinical and social services were the products of the service delivery facet of the project. Information and training sessions for health, social service and public safety professionals to facilitate understanding of the mission, protocols and resources of one another’s organizations with the goal of networking to address and reduce the prevalence of FV in the Region were the products of the system development goal.

Screening for FV was not consistent before the project began. A 2002 NE Region survey of women with a recent birth showed only 4% of respondents remembered discussing FV in a prenatal visit. When they were given a list of 22 topics from which to select those they remember discussing during prenatal visits, FV was recalled by the fewest number of respondents (66%).

1. A screening tool designed for the project was successfully developed and used consistently by MCCs.

- Almost all (97%) health, social service and public safety professionals who responded to the systems survey reported that local screening services for FV were better at the end of the project than before it began
- In contrast to the pre-project period, 96% of eligible women (MCC clients) were screened November 2004 and April 2005. Of the 1,252 women screened, 64 were positive for abuse (5%). The MCCs judged that 59 (92%) needed further assessment. Forty-six received this assessment (78%) during pregnancy. Twenty-five were assessed again at 6-weeks postpartum (54%).
- Women screening positive reported using few health and social services before pregnancy. Assessments of women during (n=46) and after (n=25) pregnancy showed increased desire for and use of services compared to use of services before pregnancy.
- Two women reported using legal services (4%) before pregnancy. One woman reported using rape crisis (2%) and one reported using domestic violence (2%) services. (Number of women between variables is not unduplicated. Some women reported using more than one service.)
- During pregnancy, there were 12 reports of using legal (26%) and 12 reports of using domestic violence (26%) services. Two women reported using rape crisis services (4%) and five using battered women's shelter (11%).

2. Women in need of referral received services and were successfully transferred to partner agencies for care.

- Assessments made during pregnancy and postpartum included evaluation of the woman's need for and referral to services. The 6-week postpartum assessment (n=25) provided information about women completing referrals made during pregnancy and their satisfaction with those services.

- The Regional Clinical Social Worker referred 14 women (56%) to DV services; 8 (57%) received DV services; all eight found them helpful. Ten women (40%) were referred to a Battered Women’s Shelter; only one received the service (10%) and the service was helpful to her. Nine were referred to Mental Health (36%); seven (78%) received the service and all found mental health services helpful.
 - For most of the other referral categories (health care, food stamps, financial, housing, etc.), all the women referred completed the referral and found the service helpful. (Since the number of events in each referral category is <20, rates should be interpreted with caution.)
3. *A systems survey (completed by 29 social service and public health professionals in the Northeastern Region) documented changes in their knowledge, skills, networking and the acceptability and comfort level of discussing and providing services as a result of the trainings, protocols and experience in addressing FV with clients and other health, social service and public safety professionals during the project period.*
- Two-thirds reported that they were not comfortable with policies and procedures related to family violence before the project began.
 - Three-fourths of the respondents said that they were uncomfortable with their level of knowledge and family violence risk and patterns before the project.
 - As the project concluded, 100% of the respondents reported being more comfortable with policies and procedures, in referring women for services and following up with other agencies on FV issues.
 - More than 90% were more comfortable with their understanding of the risks and patterns associated with family violence after the project activities.
 - More than 50% had become more comfortable following up with women who had family violence problems by the end of the project, although 20% remained uncomfortable following up with these women.
 - 95% were aware of FV policies that applied to their agency and 95% said that these policies made sense to them and that they were comfortable with them.
4. *A forum across agencies and organizations to ensure knowledge of each other’s program was successfully created.*
- Ninety percent of survey respondents reported having more knowledge of other programs and 86% noted stronger coordination, collaboration and communication between and within agencies.

5. *Results suggest that women became comfortable sharing their need for help related to FV when they came to local public health clinic settings.*

- No survey was undertaken during the project period to evaluate the acceptability of services to clients and their satisfaction. However, 25 of the 64 women who screened positive for abuse continued to participate in assessments through pregnancy and at least until 6-weeks postpartum. These women at a minimum took advantage of opportunities for reinforcement of the message that violence was not their fault, help was available, and they could make changes in their lives.
- Health and social service professionals interviewed after the project ended agreed that although some women were ready to discuss FV when first asked about it, many women needed to have questions asked in different ways and more than once before they felt a level of trust with the clinician conducting their screens.

The training provided to clinicians and the expectation that they would screen pregnant clients in each trimester of prenatal care resulted in their becoming more comfortable addressing FV as they did more screening and developed relationships of trust with their patients.

Pulling it together: Post-Project System of Care and Lessons Learned

This project had the advantage of being introduced from within an existing infrastructure of both a State-funded program for perinatal case management as well as the federally funded Healthy Start program with its Northeastern BLP Regional Consortium, outreach, training and extended case management components. These features and overall situation enabled the addition of a FV focus within the systems of care during and around the time of pregnancy — and did so with relative ease. The major stumbling block for the initiative was finding a qualified staff person to be the FV social worker/case manager specialist in this rural area of the State. It became clear once this was overcome, that the program was not only much needed and desired locally, but could fit well into a public health setting focusing on perinatal service delivery. Many lessons were learned as

discussed above and tasks accomplished as a result of this initiative. Key accomplishments and over-all successes of this program were:

- Enhanced perinatal family violence screening and intervention.
- Improved the referral network between local health departments and FV programs.
- Improved case management of prenatal clients experiencing physical or emotional violence.
- Enhanced perinatal outreach and client recruitment efforts.
- Improved multidisciplinary health education/training around FV and women's issues.
- Enhanced community commitment to eradicating family violence.

It is the intention of this effort that these accomplishments and progress made will have enduring effects and influence not only continued across the program area, but through dissemination of results and targeted publications in the NC Medical Journal and other state public policy forums, as well as mandates through the State's Title V program, will affect services and programs across the perinatal systems of care in NC.

Post-Grant System of Care

The survey of partners across the Region who are involved with systems of care provided feedback about what could be expected in the post-grant period. Items raised that would be necessary to sustain efforts included: consistent training for staff, continuing collaboration with community based organizations, and assuring the presence of a clinically trained social worker who could receive referrals and provide on-going services. Many voiced concern that without a mandate for at least yearly training on domestic violence, the momentum created by the grant would quickly diminish. One health director suggested the NC Department of Health and Human Service add training and mandatory screening for domestic violence in all clinics as a contract addendum

under services the health departments must offer each year. Consistent training for staff also ensures domestic violence remains a focus for patient care.

There were also strong opinions among the regional participants about a continued collaboration with community-based organizations. The health departments do not have the resources to provide comprehensive domestic violence services without strong partnerships with the local shelters, police, school systems, social services, hospitals and local non-profits. The groundwork has been done, especially during the last two years of the grant period, for such a community network. There was fear that over time communication would lessen among agencies without the continued presence and support of domestic violence as a key topic in the region. In an effort to combat this, the Regional Consortium Local Action Committee is currently discussing ways through which they can continue to support DV and linkages between community-based organizations in order to create a comprehensive system of care for each client in need.

Lessons Learned About Community Partnerships for Addressing Family Violence

- While there are frequently *some* activities and services that exist in a community to address FV, it will take a dedicated focus on developing the networks of care (as in this project) to bring the community's providers together to establish an explicit acknowledgement of each other's roles and domains. Only then will referral and service provision occur routinely and effectively for families and more of the families in need receive these services.
- Forging partnerships across public health, the faith community and "traditional" providers who handle abuse (law enforcement, social services, and judicial sectors) is not only feasible, but necessary, for an effective and enduring community-wide program.
- Pregnancy is a key family event that may trigger or escalate latent tendencies towards abuse and violence. It is therefore an important time to enhance services in maternity-

- related care settings through partnerships with agencies and shelters who have expertise in the area of abuse and violence to address these issues.
- Leaders of faith communities often counsel congregants experiencing abuse, but are uncomfortable dealing with it, because they (the pastors) feel they have not received adequate formal training in FV issues, and may therefore avoid the topic.
 - Once pastors receive training in FV and its management, and realize (1) how they can bring understanding through scriptures to these matters, and (2) understand where and how in the community they can refer congregants for further services...it will lead to a realization that providing guidance and healing related to FV is indeed an area that they (pastors and other leaders from the faith community) can play an integral role.
 - Men generally understand the issues and the factors leading to abuse and violence within a family; they want to know more about how they can become involved and play a more dynamic role in peer counseling and prevention. They also are under much stress and have needs of their own related to their partner's pregnancy and their growing family.

Lessons Learned About Training on FV Issues in a Perinatal System of Care

- It is possible and advisable to integrate screening, assessment, treatment, and referral services for FV within prenatal and postpartum public health clinic settings in rural communities as long as there is proper training that includes developmental, procedural, and cross-agency skill development.
- Having a FV clinical specialist — even if available only part-time in any one clinic setting — provides initial, refresher and advanced training; evaluates patients for domestic abuse and substance abuse; provides services to women experiencing abuse during and around the time of pregnancy; and ensures the continued implementation of policies and protocols. (Cf: Zachary ML et al, 2002; Clark KA, et al, 2001; Martin SL et al, 1998)
- Appropriate education and preparation must be provided to staff so that they can treat their abused patients appropriately. Providers own lifetime experiences of FV may be a factor in providing effective services and must to be considered when designing training and support for them in their day to day work. Health, social service and law enforcement professionals report ambivalence about what their personal response to

an experience of abuse would be. Such ambivalence about doing what policy and protocol recommends may stem from a personal history of childhood or adult abuse. A study in Appalachia (Denham SA, 2003) found that rates of childhood abuse were higher among healthcare workers than among their pregnant patients.

Lessons Learned About A Systems Approach to Addressing FV in Rural Settings

- Especially in rural areas, where resources and networks of care are limited, it makes sense to include screening for FV in routine care when women are likely to come forward for services — such as during a pregnancy or during well-child check ups.
- Given that local, rural agencies are strapped for resources, it will take close collaboration across community partners to share the service burden and the follow-up responsibility of reaching out to family with domestic abuse and violence issues.
- Rural areas can create their own multi-disciplinary workgroups through partnerships and collaborations since most rural areas do not have the population or resources to support multi-disciplinary agencies and organizations. Respondents to the project's Systems Survey enumerated many potential linkages: criminal justice agencies, drug and alcohol treatment programs, and noted that the BLP FV project built such inter-agency collaborations. (Cf: Petersen R et al, and; Margolis PA, 2001)
- Women in rural communities face both isolation as well as lack of privacy, making it difficult to seek confidential care for sensitive issues in clinics, or churches, or other sites where staff and providers may be their relatives or neighbors.
- Many concerns expressed by rural women in the focus group are not different from those of urban women: stress due to relationships and economic status; the need to fill multiple roles; desire to prevent unwanted pregnancy. It's finding the services and having limited options within a small town or remote rural area that may distinguish the experience for rural versus urban women.
- Screening for feelings of vulnerability can be effective in uncovering FV or abuse. (see also Goldstein et al., 2004)
- A non-judgmental attitude is more likely to elicit disclosure of sensitive and high-risk behavior from both batterers and victims of abuse according to African American male focus group participants. CATI has been shown to be an effective tool in taking

prenatal histories to elicit such disclosures. (Mears et al, 2005) Further study would be needed to determine the receptivity of poor, rural maternity clients to such technology in contrast with the comments of both MCC participants and clinic staff on the importance of building a relationship of trust.

- Networking and collaboration among organizations and agencies enhance the likelihood of effective services being offered to rural clients. Resources targeted at rural pregnant women are not widely available.

Lessons Learned About Screening for Family Violence

- Screening topics should go beyond questions about abusive behavior alone since inquiry about relationship satisfaction may yield clues about the co-existence of physical violence. (Cloutier S et al, 2002)
- The use of a screening tool leads to disclosure of FV better than incidental questioning during prenatal visits. The likelihood of disclosure is enhanced by repeated assessments throughout the pregnancy, as was also found in a study of adolescent MCC clients in NC. (Covington DL et al., 1997)

VI. PUBLICATIONS AND PRODUCTS

Forms	MCC Screening During Pregnancy Assessment During Pregnancy Following a Positive Screen Six-Week Post-Partum Assessment Three-Month Post-Partum Assessment Six-Month Post-Partum Assessment One-Year Post-Partum Assessment Training Assessment Form
Surveys	Survey of Partners and Collaborators on System Level Change Key Informant Interview Guide Key Informant Interviews Summary Focus Group Questions and Answers
Newsletters	“Family Violence: When Blue Skies Turn Gray,” <u>North Carolina Baby Love Plus Network</u> 1:2, 2003, p.1.
Training Materials	Literature Review Reports
Protocols	Policy Statement and Protocol for Health Departments
Reports	Report to the Regional Regional Consortium on the Northeastern <i>Baby Love Plus</i> Family Violence Project 2005 Systems Survey of Partners and Collaborators, June 1005

“Violence Screening and Assessment of the Baby Love Plus Prenatal Care Patients,” Sandra L. Martin, September 2005

Presentations

“Domestic Violence is a Perinatal Issue,”
Rebecca Whiteman, MA, Family Violence Prevention Fund,
Presented March 29, 2004, Jackson, North Carolina

“Trauma, Substance Abuse, and Family Violence: How Does It Affect the Children We See?” Family Violence Project Staff for presentation to CADA.

“Northeastern Healthy Start *Baby Love Plus*,” Family Violence Project Staff for presentation to NC Area L AHEC.

“Northeastern *Baby Love Plus* Family Violence Project,” Family Violence Project Staff

“The Northeastern N.C. *Baby Love Plus* Program Strengthening Systems of Care to Address Family Violence During and Around the time of Pregnancy: Evaluation Report” UNC Sheps Center Evaluation Team, May 2004

Database Formats Spreadsheet for Tracking Client Screening and Assessment

VII. DISSEMINATION/UTILIZATION OF RESULTS

The results from this program will be shared statewide within two focused areas. The information is presently being used to support enhancements to our statewide Baby Love Maternity Care Coordination (MCC) Program, prenatal case management. The Division of Public Health is working in collaboration with the Division of Medical Assistance (state Medicaid) as policy revisions are being made to the entire program. This data has been critical in planning new programmatic requirements to have MCCs focus on family violence during pregnancy through the postpartum period. Secondly, the lessons learned from this program is being utilized as part of the best practice methods in designing a community-based and focused program on addressing perinatal family violence. This is being implemented into the new statewide training program.

VIII. FUTURE PLANS/ FOLLOW-UP

Families and community members play a crucial part in preventing family violence. Thus the community is the essential place to continue conversation about preventing and ending family violence. The mobilization of the Northeastern BLP Regional Consortium is key in the follow up plans for continued action and activities. The consortium can lead the way in accessing funds to link human resources together in a united effort. Both of the regional Family Violence Conferences, approved by the consortium, were a huge success. The two conferences were primarily designed for organizations and systems of care personnel who worked with the clients of abuse. Hence, while appropriate services and responsive institutions are important components in the effort to address family violence, it takes more to generate and sustain real change. Some programs in the northeast region want to do more but do not have the necessary resources to expand and or implement critical activities. Training via the Regional Consortium allowed the families and communities that live with abuse to be included in the discussions in finding solutions. The county action committee, a subcommittee of the Regional Consortium, can initiate the assessment of concerns related to their particular county. This feedback could be used to design specialized trainings centered on expressed needs.

The Consortium, in essence, is comprised of families and community members. These community members know the cultural values, traditions and practices that support violence as well as those that can be used to effectively stop it from occurring. The Regional Consortium can continue to raise awareness, the first step toward preventing and reducing family violence. Additionally, the Regional Consortium is a vehicle to assess strengths and weaknesses of institutions whose mission is to community needs. Since the regional consortium is a vehicle for the community to articulate concerns and to

empower change, this approach creates a voice for social change, particularly for those directly affected by abuse. The challenge is to find individuals in institutions or service-delivery systems who are willing and able to change their system to meet the desires of the clients that utilize the services.

IX. Type/Amount of Support and Resources Needed to Replicate

The Family Violence project was introduced into the community through the NEBLP program. This strategy reduced the cost and time of implementation, making the incorporation of the FV project easier, given that the program components and organizational structures of the NEBLP program were quite compatible with the focus and intent of the FV project. Although the FV project was done under some very unique circumstances, the project's adaptability and capacity to be replicated rests in its ability to: 1) fit into the efforts of almost any maternity clinic or public health effort designed to reduce infant mortality; 2) address three important aspects of family violence--- community awareness/education, perinatal health care provider education, and community involvement/leadership; 3) build and/or strengthen the capacity of a perinatal health system to respond to family violence; and 4) comprehensively address family violence and abuse. Since the end of the grant period, only one of the five health departments has hired a licensed clinical social worker. In accordance with the state mental health reform, the project area's mental health centers have limited the amount of direct services they provide and have become a referral source to private providers. Therefore, the mental health centers are unable to step in to provide clinical services for public health patients. The state social work supervisor for DHHS said, "There is no clinician in place to provide continuity of care for victims of domestic violence.

Leadership at the state level should provide governance to those at local/county level to access funding whether it be full or partial reimbursement so that communities can sustain services.” The domestic violence counselor for the grant stated she felt each health department should have a trained clinician available to them so they can provide mental health referrals internally. It would be feasible to share one position among two counties when the region is rural. Sustainable funding at this point is a significant gap faced by the region. Many services were reduced because of cuts in the State budget. Regionally, funding is an issue for all of the county and community-based organizations. The State consultant for the Women’s Health Injury Prevention Branch said, “I am glad the project was in the northeast region: a very needy and rural area with minimal resources. But how replicable is it without the funding?” Funding and human resources are clearly needed to continue major pieces of this intervention. However, the groundwork required to continue the collaborative partnership and networking process around family violence has been substantially facilitated by the FV project. Funding is absolutely necessary for staff, and staff hired should have expertise in organizing/coordinating the local perinatal health system resources such that they come together to comprehensively address family violence. Having a programmatic structure in place like the Regional Consortium is essential in order to provide real leadership and voice from the community, and promote sustainability of the project, especially if initial funding is time-limited.

Appendices