

**MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
FINAL REPORT**

PROJECT IDENTIFIER INFORMATION

Project Title: Developing a System of Care to Address Family Violence during or around the Time of Pregnancy in Multnomah County
Project Number: H64 MC 0034 01
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NARRATIVE

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

The Developing a System of Care to *Address Family Violence* during or around the Time of Pregnancy in Multnomah County Project was a demonstration project developed to identify women at highest risk for domestic violence. It is well understood that at and around pregnancy is a time of increased vulnerability and need, for both the mother and child. Research indicates that women experiencing violence may be more likely to postpone prenatal care. Studies also indicate that during pregnancy women are at a greater risk of experiencing violence. In a study focusing on violence and pregnancy, Gelles¹ found a 28.3% greater risk of minor violence for pregnant women, a 60.6% greater of risk of abusive violence for pregnant women, and an overall greater risk of 35.6% for violence in pregnant women vs. non-pregnant women (Gelles, 1998).

The project's goal was to strengthen the Multnomah County Health Department's maternal and child health system of care for women who are experiencing family violence in order to: reduce the incidence of family violence in Oregon's Healthy Start catchment area; identify preconceptional, pregnant and postpartum women who are experiencing family violence; and increase the capacity of health care staff to effectively provide appropriate information, referrals and direct linkages to interventions that are age, linguistically and culturally appropriate.

¹ Gelles, Richard, J. (1998). Violence and Pregnancy: Are Pregnant Women at Greater Risk of Abuse? *Journal of Marriage and the Family*, Vol. 50, No. 3 (Aug., 1988), pp. 841-847

The program priority under which the project was funded was the Healthy Start program. Initially, the *Addressing Family Violence* project focused exclusively on the Healthy Start program area and clients. The original project area for both projects was comprised of 17 census tracts located in the Northeast Portland area of Multnomah County, Oregon and both projects focused primarily on African American and Hispanic women. In 1996-1998, there were a total of 3,070 live births (average 1,023 per year) in the Project Area, and 26 infant deaths (average 8.7 per year). The infant mortality rate for the Project Area was 8.5/1,000 live births, with infant mortality higher for post neonatal deaths (4.6/1,000) than neonatal deaths (3.9/1,000). The infant mortality rates for African Americans and Hispanics were much higher in 1996-1998: 15.0/1,000 live births for African Americans and 11.0/1,000 live births for Hispanics.

Starting in the second year, the project area for the *Addressing Family Violence* project was expanded to include the geographic regions of North and Northeast Portland. This area is contiguous with the original project area and disparities in birth outcomes extended to this area. This expansion allowed the project to reach the target populations who had been displaced as a result of changes in public housing developments. Additionally, this expansion would ensure the interventions implemented by the *Addressing Family Violence* project would be also incorporated into a larger proportion of the Multnomah County's Health Department's Maternal and Child Health block-grant funded Early Childhood Services. As will be discussed in the **Results/Outcomes** section, the project resulted in the implementation of a formalized protocol and performance measure for violence screening for all perinatal women receiving home visiting services

from the Early Childhood Services and may lead to the same type of measure for medical clinics operated by the Multnomah County Health Department.

The 1998 Oregon Domestic Violence Needs Assessment reported that approximately 1 in every 7 women 18 to 64 years of age (14.3%) in Multnomah County were estimated to have been victims of physical abuse (physical assault, sexual coercion, or injury) by an intimate partner during the past year and an alarming prevalence of physical abuse among young women between the ages of 18 and 24, with a rate of 1 in 3. Nearly 40% of these young women who were abused experienced severe violence, in which the victim needed medical or hospital care.

According to Portland Police Bureau Year 2000 data, African Americans were over-represented in domestic violence statistics. As illustrated in Table 1, African Americans made up 6.7% of the total Portland population, 22% of domestic violence victims were African Americans. During 2000, in Northeast Portland, where nearly one-fourth of the population were African American, 59% of domestic violence victims were African Americans. Latina victims of domestic violence were estimated by the Police Bureau to be comparable to the actual Hispanic population in the City.

However, the Multnomah County Violence Prevention Program believed that there was a much lower rate of reporting domestic violence by Latinas due to immigration status and fear of deportation, language barriers, and lack of information about systemic resources.

African Americans are over-represented among DV victims known to the police throughout Portland, especially in Northeast and to a lesser extent in North Portland.

	<u>Population</u>	<u>%</u>	<u>% Population African Am.</u>	<u>% DV Victims African Am.</u>	<u>% Population Hispanic</u>	<u>% DV Victims Hispanic</u>
Portland	660,486	100.0%	6.7%	22.0%	7.5%	5.0%
Northeast ²	98,410	16.1%	25.0%	59.0%	5.0%	5.0%
North ³	50,122	8.2%	13.0%	27.0%	7.0%	7.0%

Year 2000 DV Calls and Portland Police Bureau Cases By Area

North Portland, and to a lesser extent Northeast, generate more than their share (by population) of DV calls and DV cases at the Portland Police Bureau.

	<u>Population</u>	<u>%</u>	<u>Number DV Calls</u>	<u>% DV Calls</u>	<u>Number DV Cases</u>	<u>% DV Cases</u>
Portland	660,486	100.0%	8,818	100.0%	7,452	100.0%
Northeast	98,410	16.1%	1,608	18.0%	1,480	19.8%
North	50,122	8.2%	1,171	13.3%	1,101	14.7%

Source: Portland Police Bureau's Data System and DV Response Unit

In the United States, women and men of color have long complained that the dominant culture driven community systems are not appropriate for their families, context, or community life. In July 2001, the U.S. Department of Health and Human Services, Family Violence and Prevention Services Program convened a Multi-Cultural Forum on Violence against Women to develop linkages that strengthen the response to domestic and sexual violence in racially, ethnically, and culturally diverse communities.

Prior to the start of The *Addressing Family Violence* project, several domestic violence advocacy programs emerged in culturally specific communities in Multnomah

² Primary Project Area

³ Additional area resulting from expansion of Project Area

County (e.g. African American, Asian, South Asian, Hispanic, and Native American). They had done so out of a desperate need. While they are important, they were not meeting the needs of these communities. Each had developed a violence prevention and intervention methodology that responded to individual, family and community life. Unfortunately they were poorly funded and dominated by public policy standards that limited their ability to apply culturally appropriate services. While public agencies indicated that they understood, they continually fell short of achieving cultural competence because they failed to form equal partnerships and make changes in their structures.

For African American victims of domestic and sexual violence in Oregon the picture was bleak. At the onset of this project, only one program offered culturally appropriate and competent domestic violence and sexual assault services, NIA Healing Our Families. Shortly after the start of the *Addressing Family Violence* project, NIA was no longer in operation. Black women are not as likely as white women to turn to shelters unless the violence against them becomes quite severe (Coley and Beckett's 1988)⁴.

In the study, "Adjustment and Needs of African American Women who utilized a Domestic Violence Shelter," Sullivan and Rumptz⁵ underscored that black women

⁴ Coley, S. A., & Beckett, J.O. (1988). Black battered women: A review of empirical literature. *Journal of Counseling and Development* 66, 266-270.

⁵ Sullivan, C. M. & Rumptz, M. H. (1994). Adjustment and needs of African American Women who utilize a domestic violence shelter. *Violence and Victims*, 9, 275 - 285.

suffered more severe violence before entering a shelter compared to white women. Both studies suggest that many Black women view shelter access as a service for white women only.

A study done in Portland for Multnomah County found that a higher percentage of Blacks and Asians women leave shelters within three days compared to their White counterparts. Racism continues to be a barrier to receiving appropriate care for African American women who have been battered and places them at an even greater disadvantage in obtaining the resources necessary to remain free from abuse. The following are areas that continue to challenge African American women who are in domestic violence situations: housing, employment, the legal system and social service delivery systems.

Most Latina women who are impacted by family violence do not disclose their situation during a clinic visit, and are fearful of opening up to a health professional, especially one from the dominant culture. This is due in part to a language barrier, fears of immigration law enforcement, and cultural expectations. However, during a home visit, especially from a trained Spanish-speaking individual (a “promotora”) who is viewed as a trustworthy community leader from their own culture and of their own sex, many women quickly open up about their fears and difficulties.

If the promotora is a survivor of family violence, she may epitomize hope for the victim that they, too, can escape their situation and become “someone.”

The 1998 Oregon Domestic Violence Needs Assessment reported physically abused women sought health care nearly twice as often as non-abused women. Often

health care providers treat women without asking about abuse, therefore never recognizing or addressing the underlying cause of their health problems.

For most physically abused women, the health care setting represents a missed opportunity to get and receive help. Ninety-eight percent of abused women see health care providers, but only 23% of these women talked to their providers about the abuse. The health care system is positioned to play a pivotal role in domestic violence prevention since virtually every woman interacts with the health care system at some point in her life, and yet fails to seize this opportunity.

In 1998, the Oregon Health Systems in Collaboration (OHSIC) conducted a survey of staff in several private and public health care settings. Results indicated that public Health Department staff have a high level of awareness about partner violence in the populations they serve and local resources are perceived as being available for referral. However, public health staff requested skill-building training on how to:

- Screen each client for partner violence whether as victim or perpetrator.
- Intervene based on client's needs and staff member's role as physician, nurse, health assistant, receptionist, outreach worker, etc.
- Ensure that services are delivered in a culturally competent manner.
- Help victim prepare a "safety plan."
- Follow up with client on subsequent visits.
- Maintain client relationship during the process and document in medical records.

II. GOALS AND OBJECTIVES

The project goal was to strengthen the Multnomah County Health Department system of care for women who are experiencing family violence in order to: reduce the incidence of family violence in Oregon's Healthy Start catchment areas and surrounding

neighborhoods; identify preconceptional, pregnant and postpartum women who are experiencing domestic and/or family violence; and increase the capacity of health care staff to effectively provide appropriate information, referrals and direct linkages to interventions that are age, linguistically and culturally appropriate. The project was designed to achieve this goal by:

- Training and educating providers and provider staff;
- Using culturally appropriate family systems models and service providers;
- Involving husbands, boyfriends, fathers and other males in violence prevention;
- Mobilizing community resources;
- Evaluating and improving service delivery; and
- Disseminating project information.

Success in meeting the project's goal was to be measured by five core objectives. During the course of the project, wording of the first two objectives needed to be changed to clarify the measurement or because progress made during the first year set in motion a pattern that could potentially result in a violence screening rate of more than 100%. In this section, all objectives are discussed along with how each relates to the identified needs presented in the original proposal. For the two objectives that were modified, the original and final versions are presented.

Objective 1 Original: By May 2003, and each successive year, MCHD providers will increase the screening and risk assessment for family violence among pregnant and postpartum women using the adopted screening protocol by 20% over the previous year's screening rate. This rate will be increased by another 20% by May 2005.

Objective 1 Final: By May 2003, and each successive year, Healthy Start staff and MCHD medical providers serving Healthy Start clients will increase the screening and risk assessment for family violence among pregnant and postpartum women using the adopted screening protocol by 20% over the previous year's screening rate or to 100% by May 2005.

Objective 1: How it Relates to the Identified Needs and Program Purpose: This objective measures the primary intervention (screening) of the *Addressing Family Violence* project. As described in the previous section, screening for violence by health and social service providers is inadequate and an encounter with these providers is a prime opportunity to identify and address violence.

Objective 2 Original: By May 2003, and each successive year, MCHD providers will increase the use of the adopted violence intervention protocols to provide women who are experiencing domestic and/or family violence during or around the time of pregnancy with age, linguistically, and culturally appropriate interventions. The rate will be increased among all providers by 25% over the rate from the previous year.

Objective 2 Final: By May 2003, and each successive year, MCHD medical providers and other medical providers serving Healthy Start clients will increase the use of the adopted violence intervention protocols to provide women who are experiencing domestic and/or family violence during or around the time of pregnancy with age,

linguistically, and culturally appropriate interventions. The rate will be increased among all providers by 25% over the rate from the previous year.

Objective 2: How it Relates to the Identified Needs and Program Purpose: Because this was a demonstration project, this objective was developed to track the successful use of the screening tool developed specifically for this project. Learning from this measure could be used in replication projects. The tool and accompanying training would also make sure that providers are screening and intervening in a culturally competent manner—something that is missing in current health care settings as discussed in the previous section.

Objective 3 Original: By November 2002, the Healthy Start Consortium will be expanded to include a minimum of 2 women who have experienced domestic and family violence during or around the time of pregnancy and two family violence advocates who will participate in the collaborative process for improving the system of Care.

Objective 3: How it Relates to the Identified Needs and Program Purpose: This objective was developed to ensure integration of the *Addressing Family Violence* project and the Healthy Start program. As a process measure, this objective was developed to track whether stakeholders, i.e. African American and Hispanic perinatal women who had experienced family violence, had a voice in Consortium activities addressing violence. This voice would help program staff ensure cultural competence in its

activities—a much needed improvement to current resources as identified in the previous section.

Objective 4 Original: By January 2005, develop a project guide that will facilitate replication of the successful elements of this project by other Healthy Start programs, public health departments, and community health clinics to increase family violence screening and assessment rates, promote culturally appropriate interventions.

This will include guidelines and best practices for increasing the involvement of fathers and other male partners in the resolution and prevention of family violence.

Objective 4: How it Relates to the Identified Needs and Program Purpose: Because this was a demonstration project, this objective also was developed to track the completion and dissemination of an instruction guide to help others either replicate the project or tailor the project to meet their needs. The need for new programs that are culturally competent and incorporated into health care practices is discussed in the previous section.

Objective 5 Original: By May 2003 and each successive year, provide technical assistance and training to the Health Care Coalition of Southern Oregon (HCCSO) Healthy Start Project and its partnering agencies.

Objective 5: How it Relates to the Identified Needs and Program Purpose: Because this was a demonstration project and because Oregon has two Healthy Start programs working with different high-risk perinatal women; this objective was developed to ensure

the tracking of collaboration and exchange of resources and ideas with the other project. This collaboration would result in real-time learning for HCCSO who in turn, could use this learning to implement screening and follow-up interventions with perinatal women who are at high risk for family violence as described in the previous section.

III. METHODOLOGY

The goal of the project was to strengthen the Multnomah County Health Department system of care for women who are experiencing family violence and ultimately resulting in the reduction of the incidence of family violence in Oregon's Healthy Start catchment areas. The project was designed to achieve its goal by: Training and educating providers and provider staff; Using culturally appropriate family systems models and service providers; Involving husbands, boyfriends, fathers and other males in violence prevention; Mobilizing community resources; Evaluating and improving service delivery; and Disseminating project information. The *Addressing Family Violence* project made great strides toward strengthening the public system of care for women, and even succeeded in expanding the intervention to the Health Department's system of care for women in all of Multnomah County.

As will be discussed in the **Outcomes/Results** section, the incidence of domestic violence cases remained constant in the project area. Highlights of the activities used to meet the five objectives are described in this section.

Each of these objectives is discussed in detail in the **Goals/Objective** section. All activities were conducted to meet the goal of the project and how the activities relate to the individual objectives is discussed in this section.

Activities used to meet Objectives 1 and 2

- *The Home Violence Screening Questionnaire* was designed to identify the behaviors associated with partner violence and the physical consequence of that violence. The Questionnaire was innovative in that it attempts to identify violent situations from victim and perpetrator perspectives. The screening does not label persons as victims or perpetrators, and leaves the diagnosis of family dynamics and roles to a more detailed assessment. It is the assessment process that identifies behaviors in the partnership and determines the need for further client assistance or intervention. The Questionnaire was developed in English and translated into Spanish.
- Training was developed and provided on a wide-array of topics related to family violence. Initial training for providers and Healthy Start staff covered topics identified earlier from stakeholders. These topics include: screening each client for partner violence whether as victim or perpetrator; intervening based on client's needs; domestic violence issues and cultural differences; developing safety plans; following up with client on subsequent visits; and maintaining client relationship during the process and documenting in medical records.
- Training specific to the Healthy Start staff and Consortium included education on the prevalence of violence, screening rates and documentation prior to the *Addressing Family Violence* project, and training on how to be a community leader for violence prevention. In the second year of the program, additional

topics and audiences were added. Also, the program enjoyed strong partnerships with the national experts on violence prevention and effects, and with local experts on cultural considerations for African American and Hispanic populations. It was through these collaborations, that the four statewide conferences arose. Three of these four conferences were developed through collaboration with the local Men's Network, a group comprised of men from all walks of life who want to be part of positive change in the community. This strong male influence was innovative and resulted in a much higher involvement of male participants and presenters in these conferences than historically seen in local social service/health care training efforts. The cost of all the training was covered by grant funds and in-kind contributions from partnering agencies, including the Men's Network, Portland State University, the local Healthy Start program, The Family Violence Prevention Fund, and Desarrollo Integral de la Familia. See Table 2 for a complete list of trainings provided.

Table 2: Schedule of Training Provided by the *Addressing Family Violence Project*

Grant Audience	Content/Purpose	Trainings Held
Multnomah County Health Department Providers	Screening & Assessment Protocol Follow-up on Protocol Follow-up on Protocol Follow-up on Protocol Effects of DV on MCH/Cultural Competency Follow-up on Protocol (Using Audit Results) Follow-up on Protocol (Using Audit Results) Follow-up on Protocol (Using Audit Results) Follow-up on Protocol (Using Audit Results) Follow-up on Protocol (Using Audit Results) Follow-up on Protocol (Using Audit Results) Violence Prevention Domestic Violence 101 & 102	7/03—NE Field Team 9/03—N & NE Field Managers 9/03—NE Field Team 11/03—N Field Team 2/04—MCHD Providers (Family Violence Prevention Fund) 3/04—N Clinic Staff 4/04—N & NE Field Teams 5/04—NE Clinic Manager 9/04—N& NE Field 2/05—N & NE Clinic Staff 05/05 East County Clinics 11/05—Dental Clinics 7/05, 10/05, 2/06,6/06—Latina Network/Community Health workers
Community/Other Partners	Screening & Assessment Protocol Self-Care and DV Training Men Choosing Safe Relationships Overview of Family Violence Program Overview of Family Violence Program & Screening Overview of Family Violence Program Overview of Family Violence Program Overview of Family Violence Program & Screening Effects of DV on Maternal and Child Health/Cultural Competency Overview of Family Violence Program Overview of Family Violence Program Overview of Family Violence Program & Service Models Effects of Violence Power in Partnership Effects of Violence Dating Violence Follow-up on Protocol (Using Audit Results) Effects of Violence Dating Violence Improving Response to Partner Violence Improving Response to Partner Violence	7/03—Southern Oregon 9/03—Capacitation Staff and Community 10/03—HBI Men’s Statewide Conference Participants 10/03—Lutheran Family Services’ Violence Against Women Program Staff 11/03—El Progreso Mujeres’ Hispanic Access Community Project Staff 11/03—DV Health Care Network Members 11/03—DV Coordinating Council Members 11/03—D.I.F. Staff 2/04— Family Violence Prevention Fund—Statewide conference 2/04—Emanuel Hospital Discharge Planners 2/04—N Portland AFS Staff 3/04—AFS/DHS/CW Staff in project area 6/04—Men’s Network 10/04—Portland State University 8/05—Statewide conference participants 10/05—Teen Parenting Network 12/05—Family Violence Coordinating Council 02/06—Community workshop participants 02/06—Statewide conference participants 06/06—Statewide Girls’ Program 10/04—Family Violence Prevention Fund Conference (Boston) 03/06— Healthy Start Conference (DC)
Healthy Start staff and Consortium	Screening & Assessment Protocol Follow-up on Protocol Effects of DV on Maternal and Child Health/Cultural Competency Men Choosing Safe Relationships Family Violence Awareness Overview of Family Violence Program Family Violence Awareness & Infant Health Follow-up on Protocol (Using Audit Results)	7/03—HBI Staff 10/03—HBI Staff 2/04—HBI Staff (Family Violence Prevention Fund) 10/03—HBI Men’s Conference Participants 11/03—HBI Latino Family Group Participants 12/03—HBI Consortium Steering Committee 4/04—HBI Consumer Group Members 12/03, 9/04, 3/05, 1/06, and 9/06 —HBI Team& Consortium

- Technical assistance was provided on an on-going basis to individual staff and clients. On average, the Program Director provided one-on-one assistance with five individuals a week throughout the course of the project. This assistance was originally the role of the project's community health worker, but after that employee resigned to go back to school and the poor utilization of her services from the Healthy Start staff during the first year of the grant, the Project Director received permission from HRSA to not rehire this position. Funds were redirected to pay for statewide trainings, emergency funds for clients, and a no-cost extension for one additional year. Examples of this assistance includes helping a provider find a specific resource for a client, paying for a hotel stay for a women in danger, helping both providers and clients develop safety plans, and taking a client to the court to get a restraining order. This part of the project became less of a focus as the program evolved to meet the immediate needs of the Health Department and Healthy Start. This program's original design to contract out to two community-based organizations to provide help that would be culturally specific to African Americans and Hispanics would have been quite innovative in that it would finally recognize that the existing system of interventions for women was not sensitive to cultural differences in asking for help; however, as will be described in the **Outcomes and Results** section, these contracts were challenging due to budget cuts and mistakes.
- Multnomah County Health Department's Violence Prevention Committee was developed in the later years in anticipation of the end of funding for the *Addressing Family Violence* project. The Committee, comprised primarily of

African American and Hispanic employees, has been actively designing violence prevention training, materials, and interventions for Health Department.

- Quality improvement activities driven by on-going evaluation activities were carried out by the Project Director. These included regular discussions with provider teams on their screening, intervening, follow-up and documentation. This feedback loop allowed sites to identify their weak areas and to discuss barriers that prevented or limited their ability to screen and intervene effectively.

Activities used to meet Objective 3

- The Project Director became an active member of the Healthy Start Consortium and served as a link between the Consortium and the local system of care through active membership of the Consumer Steering Committee and the Domestic Violence Coordinating Council—an interagency body that was formed to identify and address gaps in and barriers to services for families affected by violence. The Domestic Violence Coordinating Council developed and staffed an e-mail/phone triage designed to assist agencies and individuals identify resources for their specific questions on services for people affected by family violence. This level of collaboration between agencies and the actual staffing of an on-going triage for services was innovative in that it required the sharing of resources and time to provide a seamless, one-stop service to women in need without facing any red tape, having to complete paperwork or without having to contact numerous agencies.

- The Project Director kept the Consortium informed of program activities including its involvement with staff from El Progreso Mujeres' Hispanic Access Community Project, D.I.F., North Portland AFS, Lutheran Family Services, the Violence Against Women Program, DV Health Care Network, Emmanuel Hospital Discharge Planners, Bradley Angle House, La Clinica de Buena Salud, Volunteers of America, The Men's Resource Network, Latina DV Providers, along with participants of the Healthy Start Men's Conference and Parents Anonymous groups. As mentioned earlier the active involvement of men in the project was extremely beneficial and innovative, and resulted in a much higher quality program.
- Throughout the program, the Consortium was asked to provide feedback on program activities including the four statewide conferences. Many of the consumer members of the Consortium had experienced family violence and had opportunities to voice their opinions on program activities.

Activities used to meet Objective 4

- This guide was designed to facilitate replication of the successful elements of this project by other Healthy Start programs, public health departments, and community health clinics to increase family violence screening and assessment rates, promote culturally appropriate interventions. The guide includes guidelines and best practices for increasing the involvement of fathers and other male partners in the resolution and prevention of family violence. The content and format of this guide was a result of feedback from staff, community partners, other Healthy Start programs, and violence prevention programs from other states.

The guidebook was finalized after incorporating feedback from the Family Violence Prevention Fund made possible by a HRSA technical assistance opportunity in 2004.

- The guidebook was available and was distributed to all Health Department providers, community partners and other interested parties by 2005. It became available on line shortly after and can be found at mchealth.org/violprev/.

Activities used to meet Objective 5

- Project Coordinator met with the HCCSO and the White City Healthy Start management to develop cooperative training plan in July 2003. Agreement was made that training will be available on an on-going basis, responsive to their readiness and needs. The agreement was that the *Addressing Family Violence* project will invite them to participate in trainings in Portland and will be available to provide training at their site as they request.
- HCCSO and the White City Healthy Start staff participated in all four statewide conferences. The cost for their participation was covered by grant funds.
- HCCSO and the White City Healthy Start staff provided feedback on guidebook and were provided with copies for their own use.
- Project Director kept in contact with the HCCSO and the White City Healthy Start staff throughout the program period and continually asked whether they wanted local training provided in their locale. For several reasons, HCCSO and the White City Healthy Start staff preferred to attend training in Portland.

IV. EVALUATION

Process and outcome evaluations of the *Addressing Family Violence* project were conducted. The process evaluation tracked whether the project was implemented as planned, and the outcome evaluation measured the extent to which the project's goal and objectives were obtained. All evaluation activities were conducted by master's level staff. All procedures were done to conform to the federal requirements for informed consent and the protection of human subjects and relevant Oregon Statutes and Administrative Rules.

All of the information learned in the process and outcome evaluations was provided to project management and staff of the *Addressing Family Violence* project, Healthy Start, Early Childhood Services, and Multnomah County Health Department (MCHD) clinics in regular reports. This information then was used by the various managers to highlight accomplishments and identify areas for improvement. The findings from the process and outcomes evaluation are discussed in the **Results/Outcomes** section.

The purposes of the process study were to compare the implementation of the program to the program as planned, and to give a complete picture of how the project funding was used in the field. In more specific terms, the purposes of the process study were:

- Describe the program activities implemented, including the educational, media and other materials developed;
- Compare the program as implemented to the program as planned, discussing possible reasons for any alterations in original course;

- Describe barriers to successful program implementation, solutions found to these barriers, and the barriers that appear to remain unsolved and why; and
- Describe specific strategies designed to reduce DV, including stronger linkages to DV service providers, and subsequent follow up.

The purpose of the outcome evaluation was to determine the extent to which the project's goal and five objectives were met. The five objectives are discussed in detail in the **Goals and Objectives** section. The project goal was to strengthen the Multnomah County Health Department system of care for perinatal women who are experiencing family violence. In more specific terms the purposes of the outcome study were to:

- Measure whether the five objectives were met.
- Measure whether the incidence of family violence in Oregon's Healthy Start catchment areas and surrounding neighborhoods decreased since the onset of the project; and
- Measure whether the project increased the capacity of health care staff to effectively provide appropriate information, safety planning, referrals and direct linkages to interventions that are age, linguistically and culturally appropriate.

Data collection for the evaluation was conducted in the following ways:

- *Chart Audits* were conducted regularly to monitor the use of the Home Violence Screening Questionnaire; violence screening via another method; disclosure and documentation of violence; intervention; safety plan development; follow-up; and poor pregnancy outcomes. Also they were used to collect more qualitative indicators that the lives of women may have been improved as a result of the intervention. These were done on random

samples for all sites except for the Healthy Start program; all of the Healthy Start program's charts were audited.

- *Healthy Start's Men's' Group* attendance lists and schedules to monitor the level at which family violence was covered.
- *Training and conference schedules and attendance records* were used to track the scope of topics covered and audiences reached.
- *Technical Assistance records* were collected quarterly to track the number, content, and recipients of one-on-one help with specific cases.
- *Training evaluations* were conducted to measure the effectiveness of the training, and learn from participants how to improve the training and what additional training should be provided.
- *Consortium Rosters* were collected monthly to track the participation of Healthy Start clients. This information referenced with the Healthy Start Database to identify whether participating clients had experienced violence.
- *Consortium Meeting Minutes* were collected monthly to monitor the activities of the group that dealt with violence prevention and related topics.
- *Healthy Start and Addressing Family Violence Team Meeting Minutes* were collected monthly to monitor the degree of integration of the two projects. Also to learn of the challenges in program implementation.
- *Portland Police Data* were used to measure whether the incidence of family violence in Oregon's Healthy Start catchment areas and surrounding neighborhoods decreased since the onset of the program.

- *Contracts* were used to monitor new resources and training (paid for with grant funds) offered to providers in order to increase their capacity to screen and intervene effectively with clients for violence.
- *Provider Team Meetings* were attended to learn about barriers to screening and intervening in a culturally appropriate manner. As well as to present on-going feedback on the progress of each site's screening, intervening, and documenting in clients' charts.

V. RESULTS/OUTCOMES (POSITIVE AND NEGATIVE)

Incidence of Domestic Violence in Project Area

The project trained more than 1600 people (400 people each of the four years it was in operation). These individuals included community members, providers, administrative staff, and clients. In addition it provided one-on-one technical assistance to approximately 1,000 individuals (250 each year). Table 2 illustrated the range of training audiences and the **Methodology** section describes the types of technical assistance provided. All the one-on-one assistance was directly provided (or indirectly to their provider to help) to individuals. Race/ethnicity was not tracked on the individuals who benefited from technical assistance, but all of the women affiliated with the Healthy Start program were either African American or Hispanic.

In order to describe the impact of the *Addressing Family Violence* project, the evaluation included the measurement of domestic violence incidence for the project area. The incidence of reported domestic violence cases in the project area was assessed using Portland Police Bureau data. These data are collected by the Domestic Violence Reduction Unit and the Portland Police Data System.

To supplement these data, HBI case files were reviewed for more qualitative narrative indications that the lives of clients may have been improved with regard to domestic violence. The incidence of domestic violence remained constant during the project period. See Table 3.

Table 3: Portland Police Bureau Domestic/ Family Violence Data Reported Domestic Violence Cases– 2000⁶ and 2005

Area	% of Total Reported DV Cases in 2000	% of Total Reported DV Cases in 2005
North Precinct	14.7%	12%
Northeast Precinct	19.8%	19.8%
Citywide	100%	100%

Lessons Learned and System Changes Based on Goal to Reduce Incidence Rate

At the time the program was conceptualized, it was anticipated that the number of clients identified with domestic violence issues, and incidents of domestic violence would tend to increase as a result of the project’s activities, at least in the early years, and the reporting to police should reflect this increase. In the later period of the grant, it was anticipated that the overall level of reported violence incidents in the project area should decline, as the services received begin to reduce the level of violence against the women served by the grant. By the second year of the project, it became evident that it was not realistic to expect a reduction in DV cases in the project area.

First, there had been a drastic shift in population in the project area due to changes in public housing availability and the gentrification of the neighborhoods comprising the area. As a result of this change in population in the project area, many African American and Hispanic clients have left the area and moved to other parts of the County.

⁶ Data source: CAMIN2 on 9/26/06; used reported date and UCR=673

Also, the rising cost of real estate in the project area has resulted in a growing population with higher household incomes. This economic shift means that more and more residents of the project area have private health insurance, so any interventions with public providers would not reach them. Second, it was a challenge getting providers to screen and intervene consistently when facing less time with clients due to redesigning (and shortening) patient visits to add capacity to each provider's daily schedule, and having to also address competing issues such as HIV screening, smoking, and depression. Also, the only community-based organization providing culturally specific services for African Americans experiencing family violence closed its doors around the time that the *Addressing Family Violence* project started due to financial and other challenges.

And lastly, comprehensive intervention support was limited as a result of the elimination of the Multnomah County Health Department's Violence Prevention Program due to the economic hardships facing all of Oregon during the first two years of this project. The elimination of culturally specific services decreased the resources for intervention for African American women. The project needed more time and needed a different approach to move providers past simply screening. The different approach has been developed and is part of a larger system change that is being driven by the Multnomah County Health Department's Violence Prevention Committee.

Performance on Project Objectives

Project Objective 1: By May 2003, and each successive year, Healthy Start staff and MCHD medical providers serving Healthy Start clients will increase the screening and risk assessment for family violence among pregnant and postpartum women using the adopted screening protocol by 20% over the previous year's screening rate or to 100% by May 2005.

Table 4: Results of Chart Audits for Objective 1

	Healthy Start (HBI)	MCHD Medical Providers (Primary Care) ⁷		MCHD Medical Providers (Early Childhood Services)
Sept 2002	40% screened	—		—
Jan 2003	68% screened	—		—
Dec 2003	89% screened 55% of these used Home Violence Screening Questionnaire (HVSQ) (n=114)	82% screened 3.7% of these used HVSQ (n=100)		77% screened 14.3% of these used HVSQ (n=100)
Sept 2004	86% screened 58% of these used HVSQ (n=127)	72% screened 6.6% of these used HVSQ (n=100)		76% screened None of these used HVSQ (n=100)
Mar 2005	80% screened 61% of these used HVSQ (n=139)	64% screened NE Portland None of these used HVSQ (n=100)	80% screened N Portland None of these used HVSQ (n=100)	69% screened 1% of these used HVSQ (n=100)
June 2006	92% screened 85% of these used HVSQ (n=99)	67% screened NE Portland None of these used HVSQ (n=102)	67% screened N Portland None of these used HVSQ (n=100)	82% screened 29% of these used HVSQ (n=103)
Project End Goal	100%	100%	100%	100%

⁷ Sample size for each PC sites was 50 for 2003 and 2004. Because there was a large discrepancy in screening rates between the two sites, in 2005 100 charts from each clinic were audited and results were separated.

As Table 4 highlights the project did show an increase in the screening rate for the Healthy Start program (40% to 92%) and an increase in their use of the Home Violence Screening Questionnaire (55% to 85%); however, the program goal of 100% for both of these measures was not obtained. Similarly, the Early Childhood Services program's screening rates increased from 77% to 82%, but this rate fluctuated throughout the project. Early Childhood Services' use of the Home Violence Screening Questionnaire was not notable until the last audit in 2006 during which 29% of the charts had this tool in it. Again, the goal of 100% was not met. Lastly, the primary care sites' screening rates and use of the questionnaire decreased from 82% and 3.7% respectively in 2003 to 67% and 0 in 2006. The goal of 100% was not met.

Lessons Learned and System Changes Based on Objective 1:

It was during the second year that the program received permission to expand the intervention to Early Childhood Services (home-visiting) and primary care settings within the project area, hence the data in Table 4 beginning for these sites in December 2003. This change was requested because the original *Addressing Family Violence* project's staff was unsuccessful in fully integrating the project with the Healthy Start program.

The Healthy Start program had been in operation for five years at the time the *Addressing Family Violence* project was designed. Unfortunately, although the creators attempted to engage the Healthy Start staff in planning efforts for this new project, they were not able to secure complete "buy-in" from Healthy Start staff. As a result of this conflict, Healthy Start staff were resistant to adopt the Home Violence Screening Questionnaire, to attend training provided by the *Addressing Family Violence* project,

and to facilitate the involvement of the new project with the Healthy Start Consortium. As a result of this situation, screening rates were low for the first two chart audits: 40% and 68%. By the third chart audit, during the second year of the *Addressing Family Violence* project, the Healthy Start screening rate jumped to 89%. This improvement was a result of the hiring of a new Project Director who had credibility with the Healthy Start staff and was seen as part of the team rather than someone from another program telling them what they need to do with their clients.

It was this mistake of not securing complete buy-in that drove the successful Project Director to develop the Multnomah County Health Department's Violence Prevention Committee comprised primarily of African American and Hispanic employees, including representation from Healthy Start. This group has been actively designing violence prevention training, materials, and interventions for peers in the Health Department.

Another change the new Director made was to incorporate the Home Violence Screening Questionnaire in each new chart as a required document. This change and her on-going meetings with the Healthy Start team resulted in an upward trend in the percentage of charts with screening being completed by using the Home Violence Screening Questionnaire. The adding the questionnaire to new charts as a required document also resulted in a jump in the use of the tool from 1% to 29% for Early Childhood Services. The tool was not added to primary care charts, nor was the Director able to talk to the clinic providers as often as desired due to the very limited time they have for outside presenters. These limitations are reflected in the screening rates and the

fact that none of the primary care charts audited had the Home Violence Screening questionnaire in them.

Feedback from Healthy Start, Early Childhood Services and primary care providers was consistent in that they thought the form was too long, too intense and therefore uncomfortable to use. As a result of this feedback and the seemingly poor results from the tool (see Table 5), the Multnomah County Health Department's Violence Prevention Committee is in the process of implementing a new mechanism for violence screening for all of Early Childhood Services, which included Healthy Start, and the other home-visiting teams covering—not just North and Northeast Multnomah County—but the entire County.

Rather than having a separate form for violence screening, they decided to make it part of a history/inventory record that will be used at each encounter. At the time of reporting, this change had been implemented for community health workers in Early Childhood Services. It is currently in progress for community health nurses in Early Childhood Services.

Family violence screening will now be one of several areas that will be covered at each encounter (depending on the pregnancy status of the client): Home Environment Assessment, Family Violence Screening, Pre-term Birth Prevention, Pregnancy and Childbirth, Health Status, Emotional Status, and Infant Care /Parenting. They will be asking whether there is a history of violence, current physical or emotional violence, and whether there is a safety plan if needed. No changes are currently in progress for primary care providers, but the Project Director and the Prevention Committee will continue to encourage primary care providers to screen for violence.

Project Objective 2: By May 2003, and each successive year, MCHD medical providers and other medical providers serving Healthy Start clients will increase the use of the adopted violence intervention protocols to provide women who are experiencing domestic and/or family violence during or around the time of pregnancy with age, linguistically, and culturally appropriate interventions. The rate will be increased among all providers by 25% over the rate from the previous year.

Table 5: Results of Chart Audits for Objective 2

	Healthy Start (HBI)	MCHD Providers⁸
Sept 2002	Not using protocol	—
Jan 2003	Not using protocol	—
Dec 2003	81% of the charts—containing documentation of actual violence—with any type of violence-related follow-up also documented. ⁹ (n=36) <i>baseline</i>	39% of the charts—containing documentation of actual violence—with any type of violence-related follow-up also documented. (n=28) <i>baseline</i>
Sept 2004	42% of the charts—containing documentation of actual violence—with any type of violence-related follow-up also documented. (n=33) <i>48% decrease from latest audit.</i>	42% of the charts—containing documentation of actual violence—with any type of violence-related follow-up also documented. (n=33) <i>8% increase from latest audit.</i>
Mar 2005	48% of the charts—containing documentation of actual violence—with any type of violence-related follow-up also documented. (n=27) <i>14.5% increase from latest audit</i>	25% of the charts—containing documentation of actual violence—with any type of violence-related follow-up also documented. (n=32) <i>40% decrease from latest audit.</i>
June 2006	44% of the charts—containing documentation of actual violence—with any type of violence-related follow-up also documented. (n=16) <i>9% decrease from latest audit</i>	37% of the charts—containing documentation of actual violence—with any type of violence-related follow-up also documented. (n=27) <i>25% increase from latest audit</i>
May 2005 Goal	100%	48.8%

⁸ Primary Care & Early Childhood Services combined due to small sample size.

⁹ Any notation of subsequent follow-up specific to the documented violence is counted. The timing of this follow-up is not considered, nor is a visit required.

As Table 5 highlights the project was unable to meet objective 1 for the Healthy Start program nor the other provider sites. In fact, the findings for Healthy Start show a steady decline in the documentation of follow-up when violence was disclosed, from 81% in 2003 to 44% in 2006. Also declining was the number of clients with the disclosure of violence in their chart. The other sites' results do not show a trend in either the documentation of follow-up or disclosure of violence.

Lessons Learned and System Changes Based on Objective 2:

Even though, as Table 4 illustrates, the screening rate and the use of the Home Violence Screening Questionnaire have steadily increased for the Healthy Start charts, the disclosure of violence and documentation of follow-up have declined. Interviews with staff pointed to possible causes of these discrepancies: the perfunctory use of the tool, using the tool too soon in the relationship with client—before enough trust was developed, the tool was too intense and intrusive—making clients respond superficially, and the elimination of culturally relevant community resources that were available at the onset of the project. Prior to the use of the Questionnaire, staff were asking clients in an more organic manner, when the time was right in the conversation—resulting in women being more likely to disclose violence and be receptive to intervention and consequently follow-up. Also, if there were no concrete places to send women—just emergency funds for a hotel room for a short time, staff were less comfortable to intervene. Feedback from the other sites included the lack of time, the length and intensity of the tool, and lack of resources to refer women to as the biggest challenges. As mentioned earlier, a shorter screening method is being developed for sites. Also, a client education packet was developed that covers domestic violence as part of a larger safety message. This was

developed by the Multnomah County Health Department's Violence Prevention Committee as a way to diffuse the material enough to make it safe to bring home, comfortable to read and not stigmatizing.

An important lesson learned about collaboration with community groups includes the need to sit down, face-to-face and build real agreements with groups with clear and realistic expectations—as well as with the internal stakeholders. This has proved to be the most challenging. A mistake made by the original Project Director resulted in misunderstandings between the County and community groups. The new Director spent significant time in rebuilding relationships with service providers, who after the first year thought that they were going to receive contracts to provide intervention services to clients but did not.

The contracts were not finalized because Healthy Start case managers believed that their clients would be more comfortable with them rather than a provider from an outside agency because they had established a trusted relationship. Because of this belief, Healthy Start staff were not interested in referring their clients to the *Addressing Family Violence* program or any affiliated service provider. The new Director was successful in engaging D.I.F. in training activities, but was unable to contract with them for providing direct service. Ironically, it was the Healthy Start staff who would later respond that there were no community providers providing direct service. The need to get true buy-in from internal stakeholders is of up most importance. Had this happened, Healthy Start staff would have been screening from the start and then linking clients to the *Addressing Family Violence* program, who in turn would connect the women to the contracted culturally relevant community providers.

To apply our learning from this error, the Multnomah County Health Department's Violence Prevention Committee—an internal group of stakeholders, including the Healthy Start staff—is currently leading the way in strengthening relationships with outside partners for future resources and activities.

Project Objective 3: By November 2002, the Healthy Start Consortium will be expanded to include a minimum of 2 women who have experienced domestic and family violence during or around the time of pregnancy and two family violence advocates who will participate in the collaborative process for improving the system of care.

The program did meet the first part of this objective with several Healthy Start consumers who had experienced domestic violence, participating on the Consortium between the years of this grant (2003-2006); however the second part was not met in the manner at which it was designed.

Lessons Learned and System Changes Based on Objective 3:

Rather than having two family violence advocates participating on the Consortium, the Director of the *Addressing Family Violence* project served as an active member and acted as the liaison between the Consortium and the local system of care through active membership of the Consumer Steering Committee and the Domestic Violence Coordinating Council—an interagency body that was formed to identify and address gaps in and barriers to services for families affected by violence. Members of the Multnomah County Health Department's Violence Prevention Committee are also members of the Consortium and these relationships will continue past the end of the *Addressing Family Violence* project.

Project Objective 4: By January 2005, develop a project guide that will facilitate replication of the successful elements of this project by other Healthy Start programs, public health departments, and community health clinics to increase family violence screening and assessment rates, promote culturally appropriate interventions. This will include guidelines and best practices for increasing the involvement of fathers and other male partners in the resolution and prevention of family violence.

The project did meet this objective. The guidebook was available and was distributed to all Health Department providers, community partners and other interested parties by February 2005. It became available on line shortly after and can be found at mhealth.org/violprev/.

Lessons Learned and System Changes Based on Objective 4:

The feedback received from stakeholders though out the State of Oregon has been positive. Because we now have findings about the effectiveness and acceptability of the Home Violence Screening Questionnaire, the Guidebook needs to be updated with the shortened screening tool and the development of an internal group of key stakeholders (frontline staff) as the responsible party for training efforts, resource development, technical assistance, and for reinforcing the need for continually screening for violence.

Project Objective 5: By May 2003 and each successive year, provide technical assistance and training to the Health Care Coalition of Southern Oregon (HCCSO) Healthy Start Project and its partnering agencies.

The project did meet this objective, with the staff of HCCSO and the White City Healthy Start attended the statewide conferences provided for free, regular phone calls and e-mails offering assistance and the guidebook being sent to them as soon as it was completed. A description of this successful collaboration is included in the **Methodology** section.

Lessons Learned and System Changes Based on Objective 5:

The project did meet this objective, but the level of technical assistance requested by HCCSO and the White City Healthy Start was less than anticipated. Part of this discrepancy could be a result of the vastly different populations the two Healthy Start programs serve. In Multnomah County, the program works with African American and Latinas in an urban setting, with urban issues. In Southern Oregon, the program works with primarily Caucasian adolescent parents in a rural setting, with rural issues. Even with this difference, the programs did successfully work together. In the future, this type of collaboration would be defined more clearly up front to avoid any discrepancies.

Outcomes that have potential for transfer and replication

All of the lessons learned can inform others in replication efforts, also the use of a shortened mechanism for screening would be recommended—along with the development of an internal group of stakeholders who are front line staff and who represent the target population for any intervention. This group then should drive the efforts and be the voice of any type of screening, intervening, and follow-up interventions.

VI. PUBLICATIONS/PRODUCTS

The primary publications/products developed by the *Addressing the Family Violence* project include the Home Violence Screening Questionnaire, The Improving Response to Partner Violence: Health Care Resource Manual, The Family Safety First client packets, and the Improving the Response to Family Violence Project presentation. With the exception of the latter, each of these have been distributed or offered to interested providers in the community, other Healthy Start projects throughout the

County, and samples are available to other interested partners. The Improving the Response to Partner Violence was developed and presented at two national conferences. A copy of this presentation is included in the **Appendix A**.

The *Addressing Family Violence* project's Home Violence Screening Questionnaire was developed as part of this project and was a central component of project's interventions. It was created in English and translated in Spanish. Its development was based on information already established in the literature and on local stakeholders. The Questionnaire was designed to identify the behaviors associated with partner violence and the physical consequence of that violence, without labeling behaviors as domestic violence. Because this tool was created for this project, its acceptance by providers and effectiveness at identifying women experiencing violence was not known. The Questionnaire is comprised of 10 questions and can either be self-administered or administered by a provider. A copy of the questionnaire is included in **Appendix B**.

The Improving Response to Partner Violence: Health Care Resource Manual was developed and disseminated as part of the project. It can also be found online at mhealth.org/violprev/. A copy of the guide is included **Appendix C**.

This guide was designed to facilitate replication of the successful elements of this project by other Healthy Start programs, public health departments, and community health clinics to increase family violence screening and assessment rates, promote culturally appropriate interventions. The manual includes guidelines and best practices for increasing the involvement of fathers and other male partners in the resolution and prevention of family violence.

The Family Safety First client packet was developed by the Multnomah County Health Department's Violence Prevention Committee. This Committee is a result of the project and has the responsibility to ensure that on-going violence prevention training, materials, and interventions are continued within the Health Department now that funding is no longer available for the *Addressing Family Violence* project. The client packets they designed include a collection of materials that are given to all clients on partner violence, child abuse, household poison safety, baby-proofing homes, and emergency preparedness. The scope of the materials in the packet is a direct result of the learning from the *Addressing Family Violence* project. Feedback from stakeholders involved in the project clearly indicated that it is safer and more culturally appropriate to make family violence prevention part of an overall safety intervention. Examples of some of the materials included in these packets can be found in the **Appendix D**.

VII. DISSEMINATION/UTILIZATION OF RESULTS

In addition to the critical, on-going presentation of evaluation findings to local stakeholders: Healthy start staff and Consortium, clinic managers, Early Childhood Services, other Healthy Start programs and local interested parties; information about the program design, products, publications, and available technical assistance was disseminated in numerous ways throughout the project. Most notably, the project sponsored four statewide Conferences that were free to providers and community members throughout Oregon and Southern Washington. These conferences covered a variety of topics relevant to violence prevention, recognition, effects, and intervention. More than 600 hundred individuals attended these full-day conferences:

- Men Enriching Neighborhoods, October 2003;
- Technical Assistance /Family Violence Prevention Fund, February 2004;
- Power in Partnerships, August 2005; and
- Revisiting 21st Century Families: Effects of Violence on Families, February 2006.

Formal evaluations were conducted for each conference and the results were used to plan the following one. This feedback process enabled conference planners to ensure that each conference provided timely and culturally competent training and resources in the areas of interest of those in the field.

The Project Director also presented information on the project's performance, preliminary findings, activities, evaluation methods and lessons learned at two national conferences during the course of the project. The Improving Response to Family Violence Project presentation was given at the Family Violence Prevention Fund's Conference on Health Care and Domestic Violence during October, 2004 in Boston, Massachusetts; and was presented again with updated information at the National Healthy Start Annual Spring Conference in Washington DC during March, 2006.

On a local level, the results of the *Addressing Family Violence* project were utilized by Health Department administration to develop a stakeholder-designed, culturally competent, and management-supported plan for integrating violence screening and intervention into the performance measures of the Multnomah County Health Department—making them required protocol for providers. See the **Future Plans / Follow-up** section for more information.

VIII. FUTURE PLANS/FOLLOWUP

As discussed in the **Results/Outcomes** section, the Multnomah County Health Department's Violence Prevention Committee is in the process of implementing a new mechanism for violence screening for all of Early Childhood Services, which includes Healthy Start, and the other home-visiting teams covering—not just North and Northeast Multnomah County—but the entire County. Rather than having a separate form for violence screening, they decided to make it part of a history/inventory record that will be used at each encounter. At the time of reporting, this change had been implemented for community health workers in Early Childhood Services. It is currently in progress for community health nurses in Early Childhood Services.

Family violence screening will be one of several areas that will be covered at each encounter (depending on the pregnancy status of the client): Home Environment Assessment, Family Violence Screening, Pre-term Birth Prevention, Pregnancy and Childbirth, Health Status, Emotional Status, and Infant Care /Parenting. Specifically, they will be asking whether there is a history of violence, current physical or emotional violence, and whether there is a safety plan if needed.

The Prevention Committee also developed and is currently using a client education packet that covers domestic violence as part of a larger safety message. These packets diffuse domestic violence messages enough to make the packet safe to bring home, comfortable to read and not stigmatizing. The packets also include inviting stickers and magnets with the DV hotline and poison control numbers readily available. The Project Director's and Prevention Committee's next steps include updating the online manual, working with the primary care clinics to develop a comparable plan for all the

Health Department's primary care clinics, and working with the Men's Network, D.I.F., Portland State University, and other potential partners to develop additional trainings and conferences that address violence. Most importantly, they will need to persistently encourage all providers to screen, intervene and follow-up with their clients.

The *Addressing Family Violence* project has highlighted the poorer than desired violence screening, intervening, and follow-up rates for perinatal women. Health Department Administration took this information seriously and developed formal performance measures for violence screening as part of its annual quality improvement program for Early Childhood Services. Additionally, it has designated funds to retain the *Addressing Family Violence* Project Director. Half of her time will be dedicated to moving the Health Department forward in its addressing family violence.

IX. TYPE/AMOUNT OF SUPPORT AND RESOURCES NEEDED TO REPLICATE

This type of screening intervention is adaptable to other home-visiting programs and possibly to primary care sites. In order for success, internal buy-in from those being asked to conduct the screening and interventions with clients experiencing family violence must be secured and maintained. Without this buy-in, it is pointless to attempt any such project. In addition to the buy-in, there needs to be internal support to ensure that those conducting the interventions are knowledgeable about any local laws and organizational guidelines that are relevant to reporting abuse, especially child abuse.

Also, it is recommended that a DV task force be formed or already in place to tailor the screening, intervening and follow-up protocol. This group should be comprised with internal stakeholders representing the target population, staff who are expected to

screen, and external/internal providers who can provide services to families once the violence is identified. One of the most important pieces of a successful replication would be the availability of community services that are specific to the women being screened. Without available, tangible services it is difficult to ensure that providers will screen. Time and time again, feedback provided from providers included discomfort in having a woman disclose violence and then not having any way to help her. Although resources were available to help, providers' perceptions of their availability was what mattered. In the *Addressing Family Violence* project, it was just one call. Even with this simplicity, some providers still had the perception that there was nothing that could be done and were resistant to screen. This was true more often in the primary care settings than the home visiting programs. In the cases where this may be true and there are limited or no culturally acceptable services available to women, two things need to happen.

First, those in power need to educate providers that asking a woman if she is being hurt is an intervention in itself. This type of questioning from someone who is in authority and responsible for helping the individual stay healthy begins to let the woman know that violence isn't "normal," or something she has to just put up with. After several times being asked, she may disclose or she might make decisions in her relationships that result in the violence ending. Second, resources should be simultaneously invested in service development when screening programs are being implemented. The cost for this combination is dependent on the local community. The cost for this level of program would require that grants be higher than \$150,000 per year. It is with these two components: screening and tangible services for intervening that could have a long-term impact on the incidence of violence.

An attempt to replicate this type of project must include resources to provide training on violence to a broad cross section of providers throughout the community. Resources should be available to bring in out-of-state experts on topics that are timely and specific to the communities being served. Because many of the participants will be working for non-profits or are community members, these types of trainings should be provided at no cost to them. It was the four statewide conferences that were one of the big successes of the *Addressing Family Violence* project. Evaluations of these conferences showed that providers from all over the state thought the information covered was useful to their daily work. The majority of participants also indicated that they would strongly recommend that their colleagues attend future meetings.

It is imperative that any site attempting to replicate such a project should have trained, experienced staff members who understand family violence and the specific needs and issues for African American and Hispanic families. This expertise cannot be learned from books, but rather from personal knowledge of the communities. Indigenous community health workers and health care providers would be ideal, if not a possibility, then staff who can work across differences need to be hired. Future projects should also include a project director who too is from the community being served or who can work with people and community groups who are different from her/him. An on-going evaluation should be included to ensure that a quality-improvement feedback loop is continually informing efforts. And lastly, performance evaluations for both individual staff and departments should include measures on whether screening, and if available, clients are linked with services.

MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
FINAL REPORT ANNOTATION AND KEYWORDS

ANNOTATION

The purpose of the *Addressing Family Violence* project was to identify perinatal, African American and Hispanic women living in the Healthy Start project area and what highest risk for domestic violence, and intervene using a collaborative approach that incorporates the services of culturally appropriate experts in the field. The project will achieve its purpose by: training and educating providers and provider staff; using culturally appropriate family systems models and service providers; involving husbands, boyfriends, fathers and other males in violence prevention; mobilizing community resources; evaluating and improving service delivery; and disseminating project information.

KEY WORDS

African Americans, Hispanics, Case Management, Child Care, Community Participation, Consortia, Infant Mortality, Low Birth weight, Neonatal Mortality, Perinatal Health, Pregnant Women, Prenatal Care, Public Private Partnership, Smoking During Pregnancy, Substance Abusing Pregnant Women, Violence Prevention.

Appendix A

Improving the Response to Partner Violence Presentation

Appendix B

Home Violence Screening Questionnaire

Appendix C

The Improving Response to Partner Violence: Health Care Resource Manual

Appendix D

**Family Safety First Education Packets:
Example Material**