Transcription

Media File Name: Safe Homes_Safe Babies.mp3
Media File ID: 2497567
Media Duration: 1:18:55
Order Number: 1871283
Date Ordered: 2016-08-22

Transcription by Speechpad
www.speechpad.com
Support questions: support@speechpad.com
Sales questions: sales@speechpad.com

Naima: Hello everyone, and welcome to the Ask the Expert, Overview of Safe Homes, Safe Babies, a train the trainer curriculum on domestic violence and reproductive coercion. I'm Naima Cozier with the Healthy Start EPIC Center and will serve as today's moderator.

We have approximately 90 minutes set aside for this webinar. There'll be a 70-minute presentation and 20 minutes for questions and answers. Questions are only submitted via the chat located at the bottom-left corner of your screen. This webinar is being recorded and the recording, the transcript, and slides will all be posted to the EPIC Center website following the webinar.

Before I introduce today's presenter, I would like to invite everyone's participation during the webinar. So at any point, feel free to enter your chat questions, comments on the bottom-left corner of your screen. Finally, immediately following the webinar, you'll receive an evaluation. We greatly appreciate your feedback and it will definitely be used to improve future webinars.

So now, I'd like to introduce our speaker for today. Rebecca Levenson is a health consultant for Futures Without Violence. Prior to her move to the consultancy world in July 2013, she worked as the senior policy analyst for Futures Without Violence from 2000 to 2013. A nationally-recognized researcher, educator, advocate and speaker, she has worked extensively in the area of adolescent reproductive and perinatal health within federal and state programs, community clinics, and home visitation programs for the past 20 years. Most recently, she's been working on trauma-informed organizational practices to support staff working with families. Let's welcome Rebecca, and I hand it over to you.

Rebecca: Well, thank you, Naima, and for my friends on the phone. It's a homecoming moment for me. You know, about 15 years ago, Futures Without Violence, received a sole-source contract from HRSA to work with Healthy Start sites across the country. So there may be some old friends of mine on this call. I had the opportunity to do 32 different site visits with different Healthy Start programs across the country and really, it was those experiences that really informed the work that you're gonna see today.

I will tell you that this is the inauguration of Safe Homes, Safe Babies. You are the first audience to have this slide deck presented in front of you. Although elements of the slide deck maybe address another curricula. This is very much developed for perinatal case managers, like

yourselves.

My goal today is to really give you a snapshot of what our full-day training looks like. So, Safe Homes, Safe Babies is a full-day training and I'm here to whet your whistle, get you excited about it. Hopefully get you thinking about things that you haven't necessarily thought about before relative to the issue of domestic violence.

So, to begin, let me show you the learning objectives. We're gonna talk a little bit about trauma-informed programming. And the main thinking that we've been doing in that area, and again none of this is exhaustive, I'm just giving you a few slides out of each of the modules. We're gonna talk about common reactions to parents or folks who've experienced trauma and how those things can affect you. We're gonna talk about why it's hard to have conversations about domestic violence with your clients. What gets in the way of our ability to do that work? We're gonna talk about universal education and the safety part innovation that teachers developed. And then we're gonna talk about that same tool, the value of it as an empowerment tool for your clients, which is something we learned along the way in our research.

If you have never met our organization before, I will tell you that we are the U.S. Department of Health and Human Services National Health Resource Center on Domestic Violence. And to break that down, it's super simple. It just means that our job, we get federal dollars to help you do the best work possible with the moms that you will work with. And so we kind of bring you the latest and greatest data, best practices, and we place it based in a way that is most meaningful to you.

And again, I'll tell you a quick story about an example about how we go about this work. One of the first site visits I did for Healthy Start was in Jacksonville, Florida. There was a woman there named Lo Gary, who was running her program. And again, this was a while ago, so I had kind of big eyes. It was one of my first site visits and she said, "You know Rebecca, if you really wanna know what gets in the way of what's going on with my folks on the front-lines, you should separate them out from the supervisors so they can tell you what's really up. And you should do the same thing with supervisors. You should do it everywhere you go so that you really have a sense of what's in the way, what do people need help with, what are they afraid of?"

And I thought that was just brilliant and we did it. We took her wisdom and really applied it. So that's an example of kind of how we work with

and for the field relative to helping understand your needs and experiences. And the barriers that get in your way sometimes to be able to have straight-up conversations with supervisors, etc.

So, to go back to our website, Safe Homes, Safe Babies is one small thing that we have developed. We have developed many, many other tools and there's a whole host of posters, and safety cards, and pregnancy drills, and the list goes on. All kinds of things that would be useful to you in your practice that I'm not covering today. Everything we develop is free for the field. I think there's a flat fee, a $10 shipping fee or something if you're gonna order materials. But a lot of the things that we have [inaudible 00:06:12] most of it.

I do want to talk a little bit about the limitations of what you're seeing today. So, this is a curriculum that we've developed for pregnant women and postpartum women, right? So this is not addressing the needs of male survivors of domestic violence. We certainly know that they're out there, but that's not what's included in here. So I'm not covering them today, but there are a number of tools in here, if you choose to download the whole curriculum, that were developed just for women, not to be used with men. That's one of the screening tools, but I won't even be covering those today. But just as an FYI.

And then certainly we know that teens… I know that some of you work with high-risk teen moms, and we know that maybe they don't even have a partner, right? So maybe they're still living at home, they're living with grandma. Maybe they're experiencing violence from someone in their family, not a partner. And this isn't addressing that issue either. So we just wanna be upfront about what we're covering and what we're not covering.

And I think a good place to start is the big gray areas, right? So why is it difficult to do this work? And, you know, some of it's personal. I think some of is related to fears around Child Protective Services for some of you and I'll talk more about that later. And then we all have our own stories when we come to this work. So our own experiences with personal or vicarious trauma can be something that gets in the way. And then I actually think screening schools can be limiting in the context of our work, and I'll talk a little bit about that again later.

So, we just really wanted to address some of those key barriers. And what we wanted to do is really pull out this universal education piece. We wanted to make it relevant for you. I think, you know, earlier on

when we were doing our work, we weren't focused on the staff and we're much more focused on that now. And there are video case studies that are part of these curricula and I want to say that those videos won't be played here, but they're things which you can look at on our website as well.

So, I know you can't see what others write in the chat box, but I can see it all. And so, these are just a couple questions for you to think about. Do you think it matters how domestic violence screening tools are introduced? Do you think your body language and/or the way you frame questions affects the outcomes of the interaction? And do you think the kind of supervision you receive affects your ability to do this work?

Now, if I were doing this live with you, I would ask you to raise your hand or ask you to call out, "Yes, no." And I see people writing in right now. Look they're writing in "Absolutely, yes," etc. So, I'm watching the chat as we go through.

You know, the answer to these all are yes. All of these things matter. So what we were trying to do is figure out, "Well, how do I help you introduce your tools in a different way? How do I help you think about where are you in this story? How are you feeling as you're engaging in a conversation about domestic violence?" And then, too, I really honor supervisors because there's things that, you know, you're only as good as what you know. And I think that stuff around vicarious trauma, secondary trauma, what are your staff's stories, how does that get in the way of their ability to do the work? It's something that you have to learn. And if you don't have tools for that or you don't have a structure for that, it's hard to know what to do. So I just wanna honor that space, too, in my work with you today.

So, I'm gonna ask you all to type in the chat box on this one. How many of you have been screened for domestic violence? There's about 37 of you on this call. So I'm curious, just how many of you have ever been screened as part of your routine prenatal care, part of your OB/GYN visit, your primary care visit? How many of you have personally been screened for domestic violence? So there's some noes and some yeses. Okay, so we'll move on.

For those of you who were screened for domestic violence, was it a good experience or a bad one? So go ahead and take a second. So, a lot of you haven't been screened. That's interesting. Was it a good experience or a bad one? You just write "good or bad." That's for me.

Good or bad in your chat box.

Well, I think that a lot of folks end up having mediocre and bad experiences and when I was just doing a training here in California about a month ago, I was doing a workshop on this same topic. And I asked, again, my group in front of me, "So tell me, you know, have you been screened? What did you think your experience was?" And so one of them said, "Well, my experience wasn't so great." And I said, "Well, tell me about that." She's like, "Well, I was in labor in the hospital in the middle of a contraction when the nurse asked me if I was afraid of my partner." And I said, "Officially, we're gonna go ahead and put that in the bad column." That's not a good idea. That's not a helpful time to try to have that conversation. So what I will ask you all as you think about that is, you know, was this nurse really sitting with this woman on where she was, or was she fulfilling a checklist that she needed to fulfill as part of her prep for delivery? I think what we're trying to do in the field is help folks come back to, "Why are we doing this? What's this all about?"

So this really gets us to do no harm, right? That's your goal. What is your personal goal when it comes to domestic violence screening? Is it data questioning? Because for some programs that's what it is. Is it to do patient education? Is it to provide support? So I want you to kind of reflect on, how do you define success and how does your program define success? Because I think it might look a little different depending upon where you sit with it.

I don't know how many of you have heard of this concept of cultural humility, but it's a place that I live in a lot. I probably live here in part because I have a lot of children and some of them are young adults or teenagers and they constantly push me to grow. But I think whenever we do our work, whether it's prenatal case management or you're working with domestic violence, then we need to continue to be informed by what's around us that we grow and adapt.

So I like this definition of cultural humility. I think it's really simple. It's not a discrete end point, but it's commitment and active engagement in a lifelong process that individuals enter into in an ongoing basis with clients, communities, colleagues and with themselves. And I say this to you because I wanna acknowledge that when we first started doing our work around domestic violence, we weren't really thinking about you. You, the actual person who's supposed to be helping those people over there, those mommies in your program.

We had a very little bit of…a few thoughts actually relative to this issue. And over the years, we've really been humbled by the prevalence of trauma among the staff, and how much we need to address that upfront. We need to talk about the elephant in the room before we can ask you to work with others. Because you matter, we care. And if we're gonna create the trauma-informed sequence of care, we have to begin with you, and your stories, and your experiences.

So, again, this is module one of this curricula and what I wanna say is you're just seeing a snippet of the slides in this section. So please don't take this as the whole story. So they mention trauma is prevalent. Of course, what we always do is recognize that there are folks in the room who may be triggered by the content that we present. So we want you to make sure you take care of yourselves. If you're in a group room and you need to get up and wash your hands, catch your breath, whatever, please take care of yourselves. I can't see you, but if we were doing this live, we would have a person in the room who could be there to support anybody who is having an issue that comes up as a result of what they see or hear.

What is vicarious trauma? And I think this is a really important place as us as staff to start thinking about how our work affects us. If you look at this, it says, "Vicarious trauma is a change in one's thinking or your worldview due to exposure to other people's traumatic stories."

I was in Michigan a little while ago and there was a woman there who had a case, a client who's 14 years old. She was pregnant. She was pregnant as the result of rape and it was a rape by someone in her family. I brought this slide up and I asked folks, "So do you have anything that comes to mind as you think about vicarious trauma?" And she said, "You know, I have a 14-year-old niece and what I find myself doing at any event, family event, community picnic, whatever, I'm scanning. I'm watching everybody. I'm watching to see how they're looking at her. I'm looking to see if she's safe and I can't turn off that hyper-vigilance inside myself." So, that's a great example of how hearing this story of her 14-year-old client impacted her personally.

So, what are some common reactions when we care for survivors of trauma? And I'm gonna go ahead and ask you to share with me in the chat box, if you wouldn't mind. What are some common reactions to caring for survivors of trauma? When you think about what your colleagues tell you or what your own experiences have done, what comes to mind?

"Anger," someone writes. I won't say your names on this, by the way. "Sadness, fear." Thank you for sharing your thoughts with me. "Anger, sadness, fear, depression." Nice. "Sympathy, compassion, hopelessness." "How careful I have to be when talking to them." Another "hopelessness, lack of compassion, anxiety."

Well, you know, you've covered in one way the big issues. Right? So, a number of you said "fear," the sense of helplessness. Nobody happened to mention sleep disruptions, but you're replaying over a conversation in your head over and over again and you can't sleep. That's certainly a part of it. A number of you mentioned depression. I think another common experience is feeling ineffective, like I'm just crispy-fry burnt. And I think that crispy-fry burnt can lend itself to feeling ineffective. But it also can be just, "I'm absolutely burnt out and I can't go back to work. I don't wanna go back to work. I don't wanna hear any more stories. Right?" So, thinking of quitting your clinical work.

Chronic suspicion of others, which is that example I gave you about the woman who had a client who had been raped. We have to [inaudible 00:17:33] the clients, we have to [inaudible 00:17:35] to coworkers, for that matter.

So, these are all examples of the real things that are happening, right, in your experience. think that we have an obligation to really address those experiences for you so that you're in a great place to help others. And I think the other thing that's very powerful in this work is that you have to know anybody can experience vicarious or secondary trauma. But we know if you have a personal history of violence, if you witnessed it as a child, if you experienced it at the hands of a partner, hearing someone else's story that is similar to yours, or you're worried about being similar to yours, could be a big trigger for you, right? And you're at greater risk for that secondary traumatic stress as a result of your own personal story. So we have to do something, right, in a different kind of way.

So, those of you who've never seen Laura van Dernoot Lipsky speak, she's phenomenal. She has a TED Talk that's about 19 minutes long, and you can look up the words "trauma stewardship" on TED Talks and you can find her talk. And this is a book that she's also written called "Trauma Stewardship." I would strongly recommend that you get this book for your programs and even read sections of it out loud. She's funny, she's super funny. And the things that we were just talking about, she's able to sort of unpack in a way that helps us not feel so alone in

the ways that we've been made to feel in our work. But also, helps us sort of have space to unwrap and talk about it and process it. So I just wanted to give you a jewel to take home with you. I think that her work is a real jewel.

You know, part of what we've learned, and again there's a lot more in this module, but part of what we learned is, you know, mindfulness, right? That ability to self-regulate, to catch your breath when you get triggered is huge. And there's lots of studies that support providers who engage at a more mindful practice do better. They have more work engagement. They have more resiliency, they're happier, they're more productive, I mean the list goes on. And some of those studies are cited in this section.

But, you know, if you think about it, I just talked about some hard things, and chances are some of you have your heart racing right now. Some of you maybe even are holding your breath, because you're saying, "Oh, my gosh, she sees me. I never even thought about that before, but that happens to me all the time."

So what do we do when we're having feelings, right? I think it's hard to listen and pay attention when we are. And so I think, you know, again, taking a deep breath in, holding it for a count of three, blowing it out. And having that integrated into our workday if there's moments when we feel a little unhinged are incredibly helpful.

So, with everybody taking that deep breath in, holding it for a count of three, and blowing it out, I'm gonna show you the second module of the curriculum. Again, it's very abbreviated. So, we're gonna talk a little bit here about domestic violence. Why is it important for you to know about domestic violence? And again, maybe there are some pieces that are obvious, right? So if you know about it, you can help somebody, etc. But I think a lot of folks don't necessarily understand how connected violence is to pregnancy outcomes and how prevalent it is. So we're gonna be talking about those things.

How common is it? We know that one in four women, this would be a really good study for abuse control data right here. One in four women will experience physical or sexual violence at the hands of her partner in her lifetime. So, I can tell you that that's a lot of folks. That's about 25% of the folks in any room. If you look at various other pieces, you may have populations with higher rates, who come from higher rates of violence.

I also think it's a health disparity issue and I think this is a very interesting frame. So, African American, Native American, and Hispanic women are at significantly greater risk for domestic violence. We know this. But I think this is fascinating, because I don't think folks necessarily know this. When differences in income, education, and employment are considered... Now think about that for a second. When the differences in income, education, and employment are considered, the differences attributable to race for domestic violence decrease or disappear. So then, we now have an economic argument, right, to be made around the issue of violence in women's lives. And I think that's a powerful frame to hold it.

You know, so if you're working with a high risk, poor population, which most of us are, right? We know that there's higher rates of violence there. And when we think about this from a social justice perspective, certainly poverty is a piece of this. So if we wanna work on violence against women, we have to address poverty. I bring this up because a lot of times screening tools are only looking at, have you been hit, kicked, slapped, or choked. It's not necessarily looking at psychological abuse. But I think this is really interesting relative to the work that you do with the moms in your programs.

So, psychological abuse by an intimate partner was a stronger predictor than physical abuse for the following outcomes: Depression, substance abuse, and developing a chronic mental illness. And so, again, if you were live right now and I was in the room with you, I would say, "So, tell me about this. Like what does this make you think?" And chances are one or two or all of you would say, "Well, it means we should really be talking to her about, does her partner respect her, does he call her names, or does she call her names. You know, the list goes on from there. So, it opens our eyes to the kinds of things that really affect the women we serve, and if we wanna understand, we need to be able to make those connections.

I think this is a really important piece and it's another group discussion. Why might a woman stay when domestic violence has occurred? And the reasons are multi-fold, aren't they? So, I'm gonna let you, again, chat in the chat box if you would and just share with me your thoughts on why a woman might stay in a relationship. And I won't share who shared what, but I will share your words. Why might a woman stay when domestic violence has occurred?

"Fear, burn out, money." Yup. "Children, income." Exactly. "Financial dependency, love." Thank you for that. Sure. Love is a part of it. She hopes the bad behavior will go away and the good behavior will stay. She's afraid of deportation. She's afraid that if she leaves, it's gonna get worse, or he's gonna kill her, or something like is gonna happen. So, I think there's a lot of reasons for why she stays, and in fact it might be the most protective thing she can do for herself is to stay and to figure out how to be safer in that relationship.

I'm bring this up because I think sometimes in healthcare, we think, "Oh, well if she hasn't left, we weren't successful," and we have to change the way we frame that, right? So, we need to understand that her staying might be her safest option, and we want her to be as safe as possible in that story. We wanna give her options, we wanna give her referrals, we wanna connect her to local advocacy programs. We wanna do all those things too, of course. We wanna tell her she doesn't deserve it.

But I wanna help everybody on the phone sort of think through, what's your goal when it comes to domestic violence? And it can't be leaving, because that, in fact, could be the most dangerous thing for her.

So how does it affect the perinatal health? Well, homicide is the second leading cause of injury-related deaths among pregnant women. So it affects women that way. And, again, I think this is something that the average case manager doesn't necessarily know, nor does the average woman. Certainly, we know that substance abuse is a real part of the story for women who experience violence, and I think this data point is really powerful.

You know, 42% of women experiencing some form of intimate partner violence could not stop smoking during pregnancy. Right? So they're all given the same messages. They know it's bad for them, they know it's bad for the baby, compared to 15% of non-abused women. So, the point of this is if you've got someone who's continuing to use, I wanna know if she's being hurt. I wanna know if you're making those connection, right, with her and with yourself.

I understand that a lot of you went through a breast feeding series and maybe this was mentioned during that series but maybe it wasn't. So, if you've got a mom who says, "No way, no how. I'm not breastfeeding." One of the things I wanna know in my head is, "Huh, is it a safety issue?" Right? Does she have a partner who thinks that those breasts

belong to them versus to her? So we know women experiencing physical abuse around the time of pregnancy are 35% 52% percent less likely to breastfeed their infants and very likely to discontinue early on, within four weeks of that baby's birth.

And so, again, I know we're passionate about breastfeeding. Right? It's a really important, great bonding thing. And you don't have to spend money on formula and it's always ready, and all those great messages you have. But if you have resistance, if you have someone who says, "I don't think so. It's not for me," I hope this fear is a way to tickle the back of your head and ask yourself, "Gosh, I wonder if this is a safety issue."

And then anybody who's struggling with chronic depression. We know that women who are in occasionally even violent relationships are about five times more likely to experience persistent postpartum depression.

And here's the issue that, you know, again, you may or may not have been aware of, right, the concept of reproductive coercion. I would ask you all what percentage of your clients' pregnancy have been unplanned? But I've done this long enough, I can answer it. Somewhere around 90% to 100%, I'm gonna guess, for most of you. What we wonder about is if folks are really taking into their control that can come around reproductive health. Right?

So, reproductive coercion is when a partner is trying to get you pregnant as a means of control, to keep you in his life forever. They do that by sabotaging your birth control, not letting you use the car to go get birth control. Saying they're gonna use a condom or pull out and don't. The list goes on. And so I think that that's just a place where, if you're looking at inner conception care, if you're looking at pre-conception care, if you're looking at pregnancy spacing issues. I wanna know if she gets to make decisions in that moment when she gets pregnant. I hope that we can have conversations with her about who makes the decisions around pregnancy in your relationship? Is it your partner who does? Do you do that together? So these are the kinds of questions I think that are really helpful.

We wanna talk a little bit about it. Because the module that's looking at assessment and safety planning for domestic violence, the perinatal case managers. I wanna start by getting a sense of you all taking a moment to reflect internally about how comfortable you are right this second with a disclosure of domestic violence. So, you know, if your needle is all the way in the dark blue on the right, at least my right on my

slide. I think it's probably right on your slide too. Do you feel really confident about what to do, and what to say, and where to refer? How to handle it? How to follow up with her? You'd be a heart in the blue somewhere, right, if that was the case.

Or are you somewhere in the red, and if you have a screening question on your form you say, "Oh, please, oh, please, oh, please, don't let her say yes. Oh, please, oh, please, oh, please don't let her say yes, because I don't want that to be true for her, or I don't know what to say, or that makes me feel vulnerable." Or "That's gonna remind me of what happened to me," or whatever, right? Where are you? And I'm hoping by the end of this talk that your needle is able to move towards the right. That you feel like you have more tools in your tool belt to do this work.

So as I mentioned, there's been a number of studies that looked at what gets in the way? What makes it hard to talk about domestic violence? I think, one of the pieces that's real is, how do you start a conversation like that? You know, it's not an easy conversation to start. I think there can be feelings of frustration and then certainly, there can be issues. I know some of you do home visitation. I know a lot of you do case management in clinical settings or in other community-based settings. But certainly, personal safety is another issue that comes up for folks.

So, group discussions. Again, if I were doing this live, we'd do a true or false in the room right now. So, "Starting and ending conversations is that difficult? Or stigmatizing issues like domestic violence can be challenging during home visits, or perinatal case management." True or false? And I think the answer would be true.

And then the second bullet point here, I think is really helpful and interesting. This is one where I think I'd get more a mix of trues and falses. Right? The first one I think we'd often agree, yeah, that's pretty true, it's challenging. But the second bullet, "We take care of ourselves by presenting questions and educational messages in a way that feels most comfortable for us." Do you think that's true, or false? I see a couple of you chatted in the chat box. True or false? What do you think? "False," I got a false here. "True." Anybody else wanna weigh in? A couple more. Okay. I would say we do. I would say that we do do it in a way that feels comfortable to us, and I don't think we're conscious of it. Okay?

So, do you think true domestic violence screening stories, they knew that they were being observed, right? And these are warm,

compassionate staff who are doing this work with women. And you can see the first quote, "No one is hurting you at home, right?" The partner is seated next to the client as this is asked. How do you think this felt to the client? And the bigger question for me as I look at this is, how dangerous could that have been? Right?

So, if in fact the person sitting next to her was hurting her at home, could that be a trigger for him to say, "You must have looked at her. You must have looked at the worker weird, and that's why she asked that question of you." So, "No one's hurting you at home, right?" Well, what's happening here. Warm, compassionate person asked the question this way. Well, it might be part of the checklist and you're required to do it. But it also might be that there's this only one possible answer when you set it up this way. Her answer has to be "No." Her partner's seated next to her. For her to say "Yes" in front of that partner would be incredibly dangerous. And so, I don't think that the staff person was conscious of doing that, but that's in fact exactly what happened.

So, what we're trying to help the field do is look at the culture. Are we seeing warm, caring folks fall into these traps that they don't even realize they're in. Learn to do it this way or they didn't realize they were trying to take care of themselves in this way.

"So, within the last year, has he ever hit you or hurt you?" Now, take a look at the next piece of this. The nurse has her back to you and she's looking at a computer screen as she asks you this question. So, if you're looking at someone's back and they're tying in the computer and they say to you, "Within the last year, has he ever hit you or hurt you?" What do you think your answer's supposed to be? It's supposed to be "No." Again, I'm sure that there was a checklist that was involved here. That was a screening question on a tool and this person is responsible for using that tool, but I also think that this person has started asking in a way to make sure that there was a "No" response.

And then lastly, "And we're really sorry to have to ask you these questions. It's a requirement of my program." And again, what is that communicating to the client? So when you all think, to the moms that you serve in your programs, what do you think your mom's greatest fear is with you all, regarding you all? What is she most worried about happening as a result of venturing into Healthy Start? What do you think? Go ahead and chat in the chat box, if you wouldn't mind. What do you think her greatest fear is?

"Being judged," mm-hmm.." Losing her child." I think the biggest fear is Child Protective Services when it comes to case management. I think that's a huge one, whether we're talking substance abuse or fear that if I tell you I'm experiencing violence, is that gonna mean that CPS, Child Protective Services, or… I know it's called different things in different states so forgive me if it's different where you are but that's where it's called in California. But I think it's the fear that they're gonna lose their child because domestic violence is seen as child abuse. And that's a barrier.

So, these are quotes from home visitation, and again I know a lot of you don't do home visitation. That you do case management and other kinds of settings, but I think that there's a lot of value in what we've learned here and that's why I'm sharing it with you. "I say no when my home visitor asks about abuse because that's how you play the game." People are afraid of social services. That's my biggest fear. Like I was saying about my friend, the reason she don't disclose is because she thinks nurse is gonna call children's services. She avoids mirrors a lot.

I think that this is real. I think it's real, whether you're a home visitor, whether you're doing perinatal case management, whether you're a doctor, whether you're a nurse, I think this is real for folks, for pregnant women or pregnant and parenting women. And, you know, our friends at Nurse-Family Partnerships who have done a lot of research looking at the nature of pregnant women and how to best serve them through case management services, just published in June of this year this study. That again, I think it has lots of value for the field of perinatal case management. What they've done is they used of a structured screen tool like this. "Have you been hit, kicked, slapped, or choked by a current or former partner?" kind of moment does not promote disclosure or any depth or exploration of abuse. Women are more likely to discuss experiences of violence when nurses initiate non-structured discussions focused on parenting, safety, or healthy relationships.

Now if you all think about this, how many of you have or know someone who has ever left something out of their medical history, or intentionally misreported information to their healthcare provider? Why? What were they worried about?

Well, you called it earlier, being judged. It might be they know what you're gonna say. It might be you didn't share with your provider what's going on with you because you didn't trust your provider. It might be that you knew what they were gonna say already and you didn't wanna hear

it. Worried about being judged, worrying about shame, worrying about messing up that relationship. There's a whole lot of good reasons why folks don't or won't share things with their providers.

So part of what we've really been thinking about at Futures is, "Well, if that's true, if only a certain percentage of women are gonna feel safe enough with that person in front of them…" Recognizing there's a power difference, recognizing they can call CPS, right? Recognizing that they can do a report, that they can do different things. A small percentage shares with you in what's going on but what about everybody else?

So if we don't rethink the way we do our practice, we're missing folks, right? So, that's a big part of what we've been thinking about in conjunction with partners across the country like yourselves. What if we challenge the limits of disclosure-driven practice? What that simply means is, if I ask you a question, "Have you been hit, kicked, slapped, or choked?" and you say "No," that's the end of the discussion. That's how this works right now. You screen, if it's a "No," you move on to the next thing.

But what about the reality that one in four women will have experienced violence? And when we look at the rates for pregnant women, we can see much higher ranges depending on the population. So we know statistically, we're not identifying lots of women who are experiencing violence. So we have to change it up. And that's really how the universal education stuff was born. We wanted to overcome the barriers created by mandatory reporting fears, and really combine. If you're using a screening tool, combine it with this universal education, or we have to say throttle it in universal education.

I don't know if you all received this. So, Futures Without Violence is really famous for these little… We call them safety cards and they're the size of a business card. They're folded up, they have multiple sides. So this card happens to be eight-sided and I'm gonna show you a couple of the panels. And when you open it up…

So first of all, let's look at the image on the front, right? I kinda wanna chew on that baby right there, with those big cheeks, right? So, what do we see here? We see a happy, attached mom and baby, right? That's what we all want for the moms and the babies in our program. So think about what it means to give an image like this to a mom versus an image of a woman with a black eye or verses a 8x11 piece of paper with typing on it. This is a story, right? We're giving her a story.

And when we open the card, we begin with the positives, right? How's it going? All moms deserve healthy relationships. Ask yourself, "Do I feel respected, cared for, nurtured by my partner? Does my partner give me space to be with friends and family or to take a break from the baby? Does my partner support my decisions about whether if I wanna have more children?" These are great questions, right? And you might be the very first person who talked about what she deserves in her relationship and that is huge.

So we begin with the positives and what you deserve, and then we move on to normalizing the negative, right? On bad days… Well, the thing about bad days is we've all had them. So, in using this language on the card, what we have done is we've created a space for conversation, right? "Is my relationship unsafe or disrespectful?" And this whole card is set up for her to be doing self-reflection.

I'll show you the script examples in just a minute about how you'd introduce the card. But, "Does my partner shame or humiliate me? Does my partner threaten me or make me feel afraid? Does my partner make me do sexual things I don't want to?" If you answered "Yes" to any of these questions, you don't deserve to be hurt and your healthcare provider can support you and connect you to helpful programs.

So, on the back of the card, there's a safety plan and then there's also the national hotline numbers there as well. But I want you to think a little bit about it. If you're in a room right now and you happen to have your business cards out, grab one of them for me. Or if you happen to have some of these safety cards with you, put one in your hand and turn to the person next to you, or think about turning to the person next to you, and what would happen if you handed that little teeny card? Well, connection happens, right? So it's small. It requires your hands are sort of near one another to give it to the other person. It requires eye contact. It's a form of connection in and of itself.

One thing that we've seen about the cards is that there were some very smart case managers in the state of Maine who said, "You know, Rebecca. This is the size of a business card and on the back of it there's this hotline panel that has the National Domestic Violence hotline on it. But if we taped our business card over that and told the mom that it was there, if her partner came across this in her bag or something else it kinda looks like one of those mommy baby things." And if there card is over that piece of it, that that could be useful too. So, that was one of the

strategies for that that I'd love to share.

So, how do we use these cards? How do we train you to use these cards? Well, we have something called CUES, it's our universal education approach. Right? So, the "C" in CUES stands for confidentiality. We wanna talk about the limits of confidentiality, so in other words, what you'd have to report and what you wouldn't. And we have to see the patient alone to do this, and I hope that's really clear. Safety first is really important, and you can only ever screen when the woman is alone. Never with a partner or a family member present because that could be very dangerous for her. But I'll give you this script about how we do the safety card intervention.

So I started giving two of these cards to all of my clients. So you have the info for you and you can help a friend or a family member if it's an issue for them. It's kinda like a buzz feed or a magazine quiz. I need you to open up the card and do a quick review. So you're not reading the card. I'm not asking you to read the card verbatim or anything like that. Just simply do this script.

It talks about healthy and respectful relationships and ones that aren't, and how they can negatively affect your health. On the back is a safety poll and a 24/7 confidential hotline with super helpful folks on it to support you or anyone you know might need help. But I will tell you, you know, we've stumbled on this issue of altruism, and it's been such an important part of the work that we've done. Because what happens when we make it about other people? It allows everyone to take the information for themselves. So even if it's not for someone else, they can take it for themselves and they can chew on it and mull it over, right? But they don't have to share anything with you today. And so for the women who don't feel comfortable at the time sharing with you what's happening to them, they can take this information and maybe they'd wanna share something with you after the fact.

Why does this matter? Why does that universal education that's tied to friends and family and helping them matter? Well, I think, you know, this is where the data helps us so much to understand how do we create more respectful places for our clients? You know, most social support studies have emphasized one-way support. Getting love, getting help, which you all do, right? So you're caseworkers, you're getting her information. It's all one-sided, right? She's not giving you anything. I mean it feels good to do the work and all that, but I mean, literally, you're the one giving her things.

The power of social support is more about mutuality than about getting herself. That is there is a need to give, to matter, to make a difference. We find meaning in contributing to the well-being of others. Now this is the big piece, right? So imagine for a second the woman in front of you that you had just given the safety card to and I'll go back so you can look at that script. [inaudible 00:46:15] survivor of domestic violence.

I've started giving these cards out to all my clients, so you have the information for you or so you can help a friend or a family member if it's an issue for them. What have I done here? I've normalized it. I've said, "We do this with everyone. We do it so that you can help a friend or family member." I think a lot of times, folks can't necessarily take steps for themselves but they may do things to help the mother. So, it's a way for her to have empathy for herself.

But we've also done something really important here, too. We told her she has value. Intrinsically, she has value. She is someone that could make a difference in the life of someone else. That is the coolest thing ever. So when you do this, and you get to watch that light bulb go off… And I have, these are studies that's coming out. It's in review right now so I'm hoping we get to see it here in 2016. But it's our second big study that we've done around safety cards. I did a bunch of qualitative interviews with providers and with women. And what was cool is I think I interviewed 24 healthcare providers about what it was like to give the card. What did they think the client thought about the script in front of you? And I think 23 of them used the same word, I think they all said "empowered." And it fits with where the data is, right?

So, I'm gonna tell you you have value. And what did that just do to my relationship with you as the worker? I just was made to feel really good by you because you told me I have the power to help someone else.

And so this is a quote from that study I mentioned that's hopefully coming out in press this year. "Giving the card makes me actually feel like I have a lot of power to help somebody." So, framing the cards for friends and family. We always give two cards. We always use the framework about helping others. We always, always, always, do this when the client is alone, not with a partner and not with anyone else. It allows the client to learn about risk and support without disclosure.

One of the panels I didn't include here but actually I have just a little bit more time so I'll mention it. It talks about coping strategies. And so,

some of the other pieces that I mentioned before like substance abuse, the depression, the anxiety, all those things. It makes the connection back to how those things can be impacted by your relationships.

So, I wanna say that there's another little square there, that I can help you in some of the other conversations I know you're having with your mom. If you have that tickle in the back of your head, you can say, "You remember that card that I showed you before? And we're gonna be talking about sort of your smoking, what's going on with that? But part of what I wanna make sure I cover today, or highlight, is I know sometimes it can be even harder to quit if you're with a partner who's scary and who's hurting you." Think about the power of that. So, there's another panel, there's a couple other panels on the card, too, that will be helpful to you.

So, if she says, "That's happening to me," what do you say back? The initial response by you is important. You wanna thank the client for sharing. You wanna convey empathy. No one deserves this. You wanna validate that domestic violence is a health issue and that you can help with it. And I'm gonna tell you how you can help with it in just a second. And that you support her without judgment.

So here's a sample script of what you might say if she says yes "If you're comfortable with this idea, I would like to call my colleague at the local program, Debbie. She's really an expert on what to do next, and she can talk with you about supports for you and your children from her program. I wanna go over this section of the safety card I gave you before. If you ever need to get out of the house quickly, it's so helpful to have it planned out. I think it's hard to think when you're really upset so having a little safety plan is very useful. So it's helpful to have planned out what you'll do, and this can help remind you about your next steps."

So, if you don't have a relationship with your local domestic violence advocacy program, I would really encourage you to give them a call. Because we're not expecting you to be experts in domestic violence, but what we are hoping to support you, and having more support for you doing this work. Because I think if you feel like you have a place to go to call and get help, you're gonna feel more confident in having these conversations with your client.

What I wanna say here too is that domestic violence agencies, I think, are often thought of with one lens. Right? So when we think about DV agencies, we tend to think about one word, and that's shelter. But

there's a lot more that they have to offer. A lot of them offer support groups and counseling. And for a lot of them, that's all they want and need. Just the idea that they can go somewhere else, hear other people's stories, is helpful and supportive. So don't underestimate the power of the collective, of knowing you're not alone, of breaking isolation. That's huge and that's really your role.

You know, why are we asking you to have conversations? Because we want that woman to know that she's not alone, people care about her. They can help with housing issues, they can help with legal advocacy. They can help you get a restraining order, they can help women file their divorce papers. Not every program is the same so I'm not gonna say if you're in Kalamazoo, it looks the same as it does in Tallahassee. But it's worth calling and finding out what programs they have available.

And why is that important? Why is giving that information important? Well, one of the things that, excuse me, we've learned is that a lot of women, even with smart phones and the internet, don't necessarily know that there's domestic violence resources out for them. So, here's a quote from… Futures does something called an e-bulletin twice a year and it takes on an issue and highlights it for folks so that they can learn more about a subject. And so, this is about home visitation and case management.

"Surprisingly many women told her that they did not know about local or national resources from which they could get help. They said that the only people they were likely to tell about a violent relationship were their friends or family members who were not always supportive." So this really highlights the importance of your role as the bridge, because there may not be anybody else for her to turn to or to get information from.

We're not gonna do this, but I would love to give you this as like a little piece that you could bring home and try out with your colleagues. I'm gonna talk about this part, getting your hair done, right? So this fabulous woman, Jenny Knight, cuts my hair, and I love her. She's been cutting my hair for 20 years, this is a true story.

And if you walk into her salon, it's just her and the chair and then there's the best stack of magazines. When you walk in, you can have a cup of tea. There's always like, you know, candies and cookies, and it's beautiful and it has a gorgeous light. If you ask me, "Rebecca, where do you get your hair cut?" And I said, "Jenny Knight," and that long description I gave you or, "Supercuts is down the road. If you turn right,

turn left, you're right there. You can't miss it." Which do you wanna do? Right? Well, I think that when you do really good case management, we're selling something. We're selling all kinds of things. Ways in which women can get access to the things that will help them have a healthy and safe pregnancy, and do a better job with that brand new baby that they're bringing home.

So, one thing I do when I do a training is I take the microphone and I call the domestic violence hotline number. I put it on speaker and as a group you listen to how many times does the phone ring before it gets picked up. And I say to the person on the phone, "Hi, I'm Rebecca. I'm in a training, and the folks in the room wanna know what would it be like if they referred a mom to you? What would that look like? What would that experience be like?" And they answer your questions.

If I have a Spanish speaker in the room, or I have someone who speaks another language, I ask them to call in that other language in another room. How long does it take for the line to get picked up? How long does it take for someone to answer you in your language? Right? So the hotline speaks… It has a language like, I think 172 languages are spoken. How long did it take?

Well, so for my Spanish speakers who do this, often, about half the staff at the hotline are bilingual. But if they do happen upon an English-only speaker, then I ask them to see how long does it take for you to get transferred over. So that you can tell your mom, you know, that, "There are people that speak Spanish. Sometimes it takes a few minutes, but there's somebody really nice, really knowledgeable, really helpful." Well, if you can say all that, right, and remember we're framing this as, you know, in case this is ever an issue for you, or for friends or family. And the hotline on the back of the card is like the greatest thing ever, so remember that. And whether it's for her or the way she sells it to someone else… because remember, now she's an extension of you in helping. Because you've given her that power, right? You can make a difference for someone else. That's a really cool thing for y'all to think about doing at like a staff meeting or after this call.

So, what have we learned about today? We learned a little bit about self-care. I talked a little bit about mindfulness and mindful movement, a little bit about trauma-informed programming, the kinds of things that I'd like these programs to be thinking about. We didn't talk so much about reflective supervision, but that's in that section. So there's having your supervisors created spaces where you can share your stories with the

hard cases, is super important for sustainability in programs, we've learned. We talked about domestic violence dynamics and its impact on perinatal health and reproductive coercion. We talked about universal education using safety cards and how to give a warm referral.

So, you've seen this before. How comfortable are you with a positive disclosure of domestic violence? I hope you feel like you have more tools and more strategies on how to have these conversations than you did before this webinar.

So, here's my chance for you all to type in the chat box because we're gonna have about a half an hour. Think about today's training. What stands out for you? What do you need more of? What's changed in your thinking? What pieces do you need answered? So what questions do you have? I want you to take some time and really think about how we can make this as valuable as possible. Because my goal is to get to as many of your comments and questions as possible.

So go ahead and take this opportunity and chat in the chat box. And then what I would think say is I'd like to leave you with a mindful movement. So, if all of you on the phone would follow along here. I'd like you to wrap your arms around yourself, your right hand over your left, and rub your arms. And squeeze yourself tight. And then switch arms and do the same. And then you stretch your arm. I'm doing this with my right. Now. I just want you to know, you're not alone looking weird. If people could see through your glass, if they can see you at your cubicle or at your desk, you're not alone. I'm wiggling my hands in the air right now too. Take your fingers, take a breath in, blow it out, and then come back to center.

And this is the final quote. This is, again, one of the business study that I'm hoping to be published here in 2016. But this is the story that stays with me. So this is a client telling about her experience around a provider giving her the card.

"So, there'll be times where I'll just read the card and remind myself not to go back. I'll use it so I don't step back. I'll pick up on this subtle stuff because it'll trigger me. I'll remember what it was like. I'll remember feeling like this. I'll remember going through this and I'm not gonna do it again. For me, it just helped me to stay away from what I got out of. I carry it with me actually. I carry it in my wallet. It's with me every day."

So, I wanna thank you for your time. I wanna thank you for the important

work you do with the moms you serve in your programs. It's an honor to have spent some time with you. And if you're interested in these safety cards that I talked about, which I'd say probably some of you might be, this is how you order them. You can order hundreds or even a thousand, if you need that many, at a time. And I think there's just a flat $10 fee. So, I'll stop here now and I will ask my friends, Michelle, Naima, if there's any questions that came up or any things that they were hoping that I would circle back around to and address in this section.

Naima: Sure. Thanks, Rebecca. First, thank you for an excellent and insightful presentation. We have one question so far, and it's, "What are the ways to have the conversation with men about domestic violence, or equality of relationships?"

Rebecca: That's a good question. I think it's a complicated…the answer is complicated, right? So, as all good questions, you know, I think if it's a good question, you gotta dig for it. I think one way that we've found that's useful to frame a conversation around helping safe relationships with men, is to talk about their own exposures. Their own childhoods, the impact that an unhealthy relationship can have on children. That empathy is a really important thing to touch in to, I think, for men.

In terms of screening for violence with men, it's super complicated. It might be a situation where she shoves him, he shoves her back, right? So there's the mutual stuff going on there. But when you actually pick it apart, what you want to understand is, who's afraid? Who's afraid of who? Right?

So you might have an unhealthy relationship where there's some stuff going on like that. But I think that really getting to the bottom of that is super complicated, which is why we tend to sit in this world where we're looking at screening tools that have been developed for women. There are very few out there that have been looked at for men. And typically, they're used for for men in same-sex relationships, not in heterosexual relationships. So it's a place where the field hasn't fully emerged and I think a lot of it has to do with trying piece that piece out.

But I would say that one tool in your tool box is, I think it's powerful for everyone to hear about safe and healthy relationships and how they can affect. They can have this... you know, babies do best, right, when they come from homes where mommies and daddies have healthy relationships. Where there aren't raised voices, there isn't a lot of arguing, there is never any hitting or hurting. And I think that there's

universal messages that you can give relative to this.

But in terms of, do I have a perfect screening tool for men? I don't. I don't think the field does, with the exception of tools to use in same-sex relationships, or ones that allow us to have conversations about healthy and safe relationships. Any other questions for me?

Naima: No other questions came in through the chat. Let's give folks a little bit more time to see if there's any questions. Oops, one just came in. "Is there a way we should approach relationships where there are signs of abuse from both partners?"

Rebecca: Well, you'd never do it with both of them. You always separate folks out and I think it's a question of who's your client in this story. So, I'd probably start with the mom. And I think if you see marks, I think it's a fair thing to talk about what you see and what your concerns are relative to that. "So, I can't help but notice that mark on your arm and I'm just wondering, did somebody put their hands on you? Are you feeling at all unsafe in your relationship or in your, you know, is anybody hurting you in your life?" That kinda thing. So I think you always wanna address injuries like that. But you'd never, ever do this with both partners in the room, for so many reasons connected to danger. I'm glad for the question. Thank you.

Naima: There's another one that came in, Rebecca. It says, "Do you ever try to engage the companion or family member during a visit with the intention to form an ally, especially when there's a sense that that person could..." And that's the only part I don't see. It doesn't look like it's totally complete. Oh, here it is, "...could be a tattletale or indifferent, but could contribute to the aggressive behavior with the partner?" So, let me repeat the whole thing. "Do you ever try to engage the companion or family member during a visit with the intention to form an ally?"

Rebecca: No. No.

Naima: Okay.

Rebecca: No. Never. Not ever. No. No. [foreign language 01:04:43], other languages. So, feel free to include them in this response. And I get where you're going. Right? I love people who think outside the box and are problem solvers and maybe there's a way to strategize around Auntie and whatever else. I mean, I get it.

But, you know, because we don't know about the relationships between the abuser and that other person in the room, or how they use people for surveillance. And for any of you who've worked around this issue or you've had situations where, you know, your moms will say, "Oh, my god, it's my mother-in-law. That's like such a nightmare. "And you know, "I think she makes my partner's behavior worse," and whatever else. You just don't know how they're being used. And the same thing is true with older children, right?

Just like we say, we never have those conversations, ever, in front of anybody other than that woman. You also wouldn't have it in front of a woman with older children. So we say three and under is fine, four and over is not. And it's because, if you have a really smart abusive partner, he's gonna say, "Honey, what did the doctor talk to mommy about today at her visit? What questions did they ask her?" And so, what we do in those situations is we might even write out our universal education script, or modify it slightly, and then give her something in writing to read. So that the child can't read it or see it. So, the safety concern is a real one. And for any of you who've worked with abusive partners, they come off, often, sweet as sugar and pie, and are using people and using situations, even work situations.

So for my friends on the phone who have known a colleague who's experienced stalking, and you know, I was the director for Planned Parenthood here in California. I ran three sites and we did perinatal case management, that's actually how I started. Doing perinatal case management within our clinic setting and we had a woman who was being stalked, and she was working the phones for us. And he would call to do surveillance on her. So if one of her colleagues would answer the phone, he'd say, "Oh hey! It's Alan. Is Melody there?" I'm making up the names by the way. And they're like, "Oh! Hang on. Hey Melody. You know, oh, he likes you so much. He's calling again." I think if Melody had an opportunity or didn't feel safe enough to tell us what her story at that time. So, I didn't…again there's other pieces in this tool kit. But one of the other things that we have for any of you who are supervisors or directors of programs. You know, we definitely have a tool kit for you on how to create safe and healthy workplaces for your staff who may be experiencing the same things that your clients are. So, I share that story because I don't think that these conversations necessarily happen in that way with your own staff, and we'd really like to see that changed.

Naima: So Rebecca, follow up to what you were just speaking to. Someone asked, "How would you recommend getting a mom alone if

her partner comes with her to all the visits?"

Rebecca: Thank you for asking that very good question. It so depends on the site. Maybe what you'd need to do, like if he comes to every visit that's a warning sign to me, just so you know. It could be that he's the most dedicated partner on the planet, but it also could really be an example of a real controlling partner, right? Does he answer all of her questions for her, etc.?

I might call her on the phone and ask her if she's alone and ask her if she can talk at another time. I might say, "Oh, you know what? We have this really cool video for daddies. And so you're gonna watch that video and we're gonna talk about sort of, you know, something gross that he's not gonna wanna talk about, right?" So about episiotomies, and things like that.

So you watch your video, and then we'll all kind of regroup. So you give him something positive to do. I think it's really complicated to say, "Okay, now, we want you to leave because we're gonna talk about something we don't want to include you in." You have to figure out a fun way to engage them. Or if you have another colleague, or even at that age group, you might say, "Hey, we want you guys to come. There's a workshop for dads. There's a workshop for moms." And the mommies workshop could be totally about safe and healthy relationships and the dads are watching a great 15 long video.

So, there's a lot of strategies that I've seen people use. It might be that she needs to use the restroom, and for any of you who are working in that clinical setting, I know not all of you do. But we would use that as an opportunity lie, "Oh, we need you to do a clean-catch urine sample." So he's not going with her into the bathroom to use a clean catch urine sample, but we would have a nurse go in with her and teach her how to do that clean-catch urine sample, but also ask her about violence. So those are just some strategies that I would suggest.

Naima: Thank you. And there's one more. "What if the child reports domestic abuse, but the mother who is our client denies it?"

Rebecca: Mm-hmm. I love children, you know, because they are the truth-tellers. My 8-year-old… I have a 26-year-old, a 20-year-old, a 15-year-old, and an 8-year-old. My eight-year-old will tell you like it is. There's no filter still. It's like, if she doesn't like your shirt, she's gonna tell you she doesn't like your shirt. If she had a bad morning with

mommy, she's gonna tell you about her bad morning with mommy. There's no filter there. There's no social filter there.

And I think that if a child says, "I saw mommy hit daddy," I bet mommy got hit by daddy. Right? And mom says, "Oh no, no, no honey, that didn't happen. That's not what's happening." I think you go with hearing the mom, right? So it's like, "Oh, I hear nothing happened but, you know what... It's so funny because we have started having this conversation with every single mom in our program. So it's like a perfect time for me to have this conversation with you. Because you wanna make sure that everybody is safe." And we know that a lot of women struggle in their relationships with their partners and we wanna make sure everybody has tools to help other people, if it's an issue for them, or tools to help themselves

Again, I'm not looking for her to say, "Yes, this is happening to me." I can't, right? She's, maybe again, afraid that you're gonna call Child Protective Services if she says, "Yes." Her child just said, "I saw daddy hit mommy." So, she's desperate to not have that be the truth, but she's maybe also desperate for some information and some help and know she's not alone.

So can we take that and use that exactly as she's presented it to us, as a way to help her have that conversation, you know, safely by herself when she's ready? And that's, I think, the beauty of universal education. And you could even say, "I'm glad that's not happening in your relationship." But here's what we started doing with everybody. We're giving this information because relationships can change, right? Things can change with a partner, and everybody deserves to know where they can go to get help, and to know how to help somebody else. Because a lot of times we all feel helpless when we see somebody, and we know something's

going on, but we don't know what to do." And just leave it at that. You did your job. Good job you, right? You created a safe, empathetic place where you didn't ask her to do something she told you wasn't going on. She's like, "I'm not talking to you about that." Right? I'm denying this. That you gave her a way out and a way to hear, and I think that's really essential.

Naima: Thanks Rebecca. And there's one more question. If you can just share again how folks can access the safety cards.

Rebecca: Now, can you all still see the slides. Can you see? I can see the slides, can you?

Naima: Everyone should still be able to.

Rebecca: So, it should say, "To order cards or other materials from Futures, please contact Melody Pagan at mpagan@futureswithoutviolence.org, or you could go to our website and order them that way.

Naima: Thank you. Yeah, I don't see any more. I think we've answered all the questions. Let's do another call. For questions, please enter 'em in the chat box. If there's anything else you wanna ask Rebecca.

Rebecca: Hmm, I just wanna add. I just think I've said this before. But there's just a lot more where this came from. It's always a little hard for me because I have to leave a lot of jewels behind. There's a lot of other material that I think would be very helpful to you in your work.

I think one thing that I wanna say, because it's come up a number of times about partners in the room, and we have this in the longer version of the curriculum. It can be hard to make a change, especially because I know that a lot of your programs you're trying to engage daddy. And I love, you know... most of them are good. Right? It just that cancel the bad eggs out there that are very destructive and dangerous and bad. Right?

So I wanna to acknowledge that and I also want to say, "How in the world do you go from a partner coming into every single visit, to changing that dynamic or that standard?" And one strategy that we've used is, literally having clinics or programs perfectly designed that says we always see patients in the room first. And we've literally had folks say it's a requirement of the HIPAA, it's a requirement of the Federal Government, it's a requirement of whatever. So that it's not about that dad or that mom, but it's just a requirement of your program at large. Right?

We've made this for, "I know it's kind of a pain, I'm sorry about this." You can empathize with the partner. "It's like we just, we have to see everybody in the room first at some point in that visit and then we have you come back later, after." And that can be a way to help change the established patterns with partners. Because I've done a lot of work in rural settings, or community clinics where like the grandma went to the

community clinic, the mom went to the community clinic, now the daughter's gonna the community clinic to get her prenatal care. And this is how it's always been done. The partner always came back.

How can you make a change? And it's like, you know what, you do it. You do it with great big fonts. You laminate it, you stick it on the wall. You let folks know that "Hey, there's been a change." And you don't make it negative, you make it positive. You say, "It's kind of a pain for us but we're working through it too, and we really appreciate your support." Right? So, it's just, you're part of our team. We're stuck, you're stuck. Let's make the best of it. And that's been a good strategy for reducing the tension that can come up when you make a change. So really being mindful of how you present it, matters.

Naima: Right. And it looks like we don't have any other questions submitted in the chat box. So, we can... I don't know Rebecca if there's anything else you wanted to add before we close? And maybe in the meantime someone will add in a question.

Rebecca: I just would say again, I think you all do some of the most important work there is to do. I believe that you are in a role to help change outcomes for babies and for mommies. And I think you're in a really unique position to help somebody who has nobody else to turn to, no other safe place to go to. And that that is gonna do more for her, her pregnancy, and her birth, and her baby. You know, helping reduce her isolation, helping her be safer in her relationships, helping her in whatever ways she wants to be helped is just huge. Because there's so much stigma around talking about this. So I guess there's that.

And then I'd also say, I gave you my sample scripts, right? And of course, what we'd do if we had a full day is you'd be kind of modifying or making them into your own, right? So that it feels right for the person in front of you. So, yes, you need to include the thing about friends and family. We'll give everybody two cards, or four cards, or eight cards. If you think that's relevant in your community, do it. We've had people ask for the whole stack, and I'm not kidding when I say that. "Can I have all these? I'm working with this [inaudible 01:17:49] group and I wanna make sure that I give one to every single woman in my group. Because I'm worried, and nobody's ever talked to them about this stuff." I mean, we've had that experience. So, in any case, I would say, use your voice, find your voice, and thank you.

Naima: Thanks, Rebecca. And before we close, we just wanted to have

folks mark your calendars for two webinars next month in September. One will be an Ask the Expert on Parenting, and the second will be an "Introductory Webinar On the Benchmarks and Screening Tools." You will get the registration information in the latest EPIC Center training announcement email, or you can go directly to the EPIC Center website.

As a reminder, please complete the evaluation following the webinar. Again, we'll be definitely using your comments to improve our future webinars. And with that, this concludes our webinar for today. Thank you so much for your participation, and we look forward to having you on future webinars. Have a good afternoon.